15 September 2007
Chemist+Druggist
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C+D

Reservoir cash: Bradshaw pays £3m to set up regulator

Multiples oppose RPSGB fee hike

Stoma supply set for shake up under DH plan

- Clinical: treating and managing hypo- and hyperthyroidism
- UniChem conference: MURs, IT and wholesaling changes

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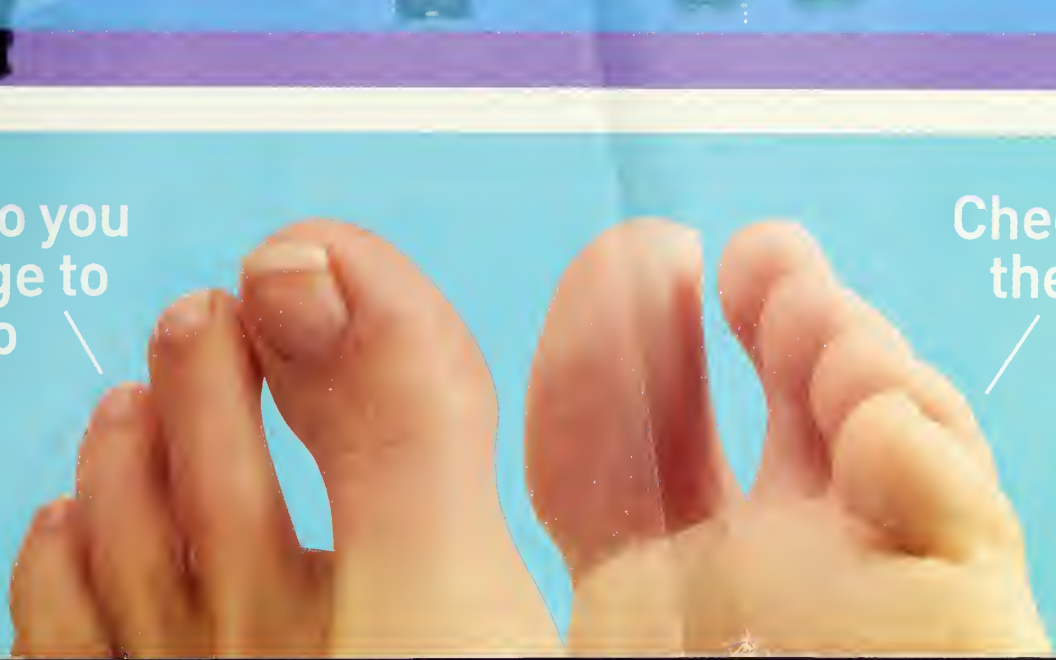

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Department of Health promises £3m towards regulatory costs

Health minister announces donation in keynote address to British Pharmaceutical Conference

Max Gosney

The government announced a £3 million sweetener to fund its overhaul of pharmacy regulation at the British Pharmaceutical Conference in Manchester this week.

Minister of state for health services Ben Bradshaw said the sum might not address all concerns over the creation of a General Pharmaceutical Council; But the move will help share "costs which otherwise may have fallen on the profession itself," he added.

The money will be paid between 2008 and 2010, Mr Bradshaw revealed in his keynote address.

The donation follows demands from the RPSGB that ministers meet the cost of mandatory changes to the way healthcare professionals are regulated. Society treasurer Andrew Gush said: "We see this as the first step and will continue engaging with the Department of Health on funding."

The £3m contribution will be kept under the control of the Professional Regulation and Leadership Oversight Group, which is charged with leading professional and regulatory change.

The group will work hand in hand with the profession on establishing a new regulator, BPC delegates heard.

Mr Bradshaw said: "We will ensure that we are thorough and work with you in establishing the new regulator.

"As the minister overseeing the programme of change to professional regulation across the health professions, I am already aware of the concerns that many of you have."

Minsters will "be careful" not to lose the 160 years of regulatory experience offered by the RPSGB, Mr Bradshaw said.

However, the government had been right to separate the Society's dual role as regulator and professional leader, he stressed.

Mr Bradshaw said: "I know the Society has tried to move towards a structure to promote independent professional regulation within an organisation that already has professional leadership in its remit. But healthcare is changing, and pharmacy practice alongside it."

Joe Miles

Ben Bradshaw: money won't address all concerns but will relieve financial pressure

Pharmacists are to play a more prominent role in tackling sexual health problems and seasonal flu, under government proposals.

Health minister Ben Bradshaw told BPC delegates: "People like going to pharmacies for these services because of their accessibility and convenient opening hours. We want to build on this."

The government will work with the profession to ensure service standards and necessary training support for providing extra sexual healthcare, Mr Bradshaw said.

The DH will publish a national template service specification to ensure pharmacies feature in PCT flu immunisation programmes, the health minister revealed.

What do you think of the DH announcement?
mgosney@cmpmedica.com

Guarantees sought

Ministers must give assurances over funding before pharmacy-led clinical services can get off the ground, the president of the Royal Pharmaceutical Society has said.

Hemant Patel urged the Department of Health to tackle the financial difficulties that have plagued enhanced services in its autumn white paper on pharmacy.

"Give pharmacy a holistic lasting settlement that will give us a period of certainty to build new improved clinical services," Mr Patel said in his address to the British Pharmaceutical Conference this week.

He added: "We will deliver our part but we need your help to remove some of the barriers and to put the right incentives in place."

The RPSGB president called on the government to "look carefully" at the all-party pharmacy group report on the future of pharmacy. The report endorsed national funding for a host of clinical services such as blood pressure testing.

Turning to the RPSGB membership, Mr Patel called for pharmacists to engage with the Society. He thanked pharmacists for their support and pledged to work on behalf of members in the future. Mr Patel made no mention of the disgruntled reaction to the Society's plans to increase retention fees by 50 per cent.

Joe Miles

Hemant Patel: we need a period of certainty

Society not engaging ordinary members

The community pharmacists that make up 70 per cent of the Royal Pharmaceutical Society's membership are not a "silent majority", according to Scotland's chief pharmacist Bill Scott.

"You do not have your radar pointed in the right direction," he suggested to Society officers at the BPC on Monday. "You need to find out what they are doing now and in the future. They will make or break the new professional body."

Other pharmacists echoed his concerns that the Society is not engaging effectively with community pharmacists on how a new professional body should be structured. Graeme Millar said that most of the smaller groups that had been sounded out represented pharmacists who worked in the managed sector.

RPSGB Council member Graham Phillips acknowledged the Society needs to access ordinary members. Research by consultants Opinion Leader, involving six focus groups and 38 in-depth interviews, was underway to help inform the Society what members want. There will be a formal consultation on the structure and functions of a new professional body, he promised, and urged pharmacists to "create the professional body you want to belong to". **PG**

RPSGB seeks your views on its future – p8

Visit C+D's clinical archive at:
www.dotpharmacy.com/upmain.html

Multiples fight retention fee hike

The UK's largest pharmacy retailers and the Royal Pharmaceutical Society are ready to do battle over retention fees, after the Company Chemists' Association requested an "urgent" meeting with the RPSGB treasurer.

The CCA could see no justification for proposed increases of 50 per cent in individual fees and premises fees, chairman Digby Emerson said. It was opposed to members including Boots and Lloydspharmacy funding any cost of splitting the Society into separate professional leadership and regulatory bodies.

"Until CCA companies are satisfied that the RPSGB has explored all possible ways of minimising the impact of fee increases on pharmacists and pharmacy owners, we will continue to oppose these proposals," Mr Emerson said.

The CCA will meet with the Society to discuss its concerns later this month. But RPSGB treasurer Andrew Gush hit back at Mr Emerson's comments, calling his reference to the demerger "a red herring".

The Society was in agreement that the cost of the split should be met by the government, Mr Gush said. "In contrast, in opposing the proposed increase in premises fees, the CCA, as the voice of the large multiples, seems quite happy to see individual pharmacists subsidising the premises fees for their members."

But CCA chief executive Rob Darracott said the issue was not the fee levels themselves; rather, the figures behind the proposals.

"If the RPSGB can present a fully costed business case, the CCA will then be in a position to assess whether the increases represent value for money. Currently, we are unable to do this," Mr Darracott said.

Read the RPSGB treasurer's full response at www.dotpharmacy.com/news **JR**

Out-of-hours under scrutiny

Alan Johnson has outlined plans to boost the role of pharmacists in out-of-hours care.

The health secretary criticised GPs for inconvenient opening hours in an address to an NHS think tank, as C+D went to press.

He called for more primary care to be provided in pharmacies, schools, sports centres and walk in centres.

Mr Johnson said: "It is an anomaly that surgeries open as the nation starts work and close when we finish. We need to ensure there are more routes into primary care, including high street pharmacy."

This follows a report from economist Sir Derek Wanless that claimed increased investment in the NHS over the past five years has not produced satisfactory results. The report concludes that spending on healthcare will need to rise to £161 billion by 2022, unless steps are taken to increase efficiency. **JC**

Expert PBC advice panel unveiled

An expert panel is set to answer pharmacists' practice-based commissioning questions during September's PBC Awareness Week.

The panel includes pharmacists, commissioners and policy implementers and its advice will therefore represent the full PBC picture, said panel member and NPA head of NHS service development Stephen Fishwick.

"Together the panel has a 360 degree perspective of PBC," he said.

During PBC Week, which runs September 24-28, pharmacists can email their queries to pbcexpertpanel@npa.co.uk. The experts will respond collaboratively within 24 hours, Mr Fishwick said.

"We hope that people will make maximum use of it because this is a genuine expert panel, individually and collectively, and they're there waiting for your call."

- A PBC template for sexual health services, produced by C+D and the NPA, will be available at www.dotpharmacy.com/PBC from next week.

The PBC panel

Policy implementer:

- **Trish O'Gorman** of the Improvement Foundation, organisers of the DH-sponsored PBC collaborative programme

The commissioners:

- **Peter Johnstone**, pharmacist and general manager of Liverpool Health Care PBC Consortium
- **Tim Jones**, commissioner at Milton Keynes PCT
- **Richard Gee**, GP lead for Dudley PBC consortia

The pharmacists:

- **Mike Holden**, chief officer at Hampshire & Isle of Wight LPC
- **Ash Soni**, NPA board member
- **Stephen Fishwick**, NPA head of NHS service development. **JR**

C+D winner

Dr Mary Tully picks up this year's C+D Practice Research Award medal from our online editor Tom Hawkins at the British Pharmaceutical Conference in Manchester.

Dr Tully, clinical senior lecturer at the School of Pharmacy, University of Manchester received the accolade for her work on the process and outcomes of prescribing in secondary care.

Dr Tully said: "I am really proud to have been chosen to receive the C+D Practice Research Award. It is undoubtedly one of the highlights of my research." **MC**

Dr Mary Tully collects the award medal from C+D's Tom Hawkins at the BPC in Manchester

PBC week
September 24-28

Step 6 of our guide to writing a PBC service proposal looks at taking stock of where you are now. For steps 1 to 5 and PBC templates see www.dotpharmacy.com/PBC

A step-by-step guide to PBC

STEP 6

Prepare your pitch

Stephen Fishwick, head of NHS services development, NPA

The nature of your pitch depends heavily on the stage at which you are entering the local PBC planning cycle. If you are making proposals at the earliest – 'service redesign' – stage, you are unlikely to be pitching a detailed service proposal. Instead, an informal, verbal approach may be the best way to proceed.

At the later – 'procurement of services' stage, where the PCT will tender for services or invites 'any willing provider' to express an interest, the PCT will probably specify a detailed application process and paperwork. In the absence of specified paperwork, you may at this stage wish to use the NPA PBC templates as the format for submitting a 'provider business case'. Even where the PCT specifies a format, it is likely to cover the same core components as those laid out in the NPA's PBC templates.

If the PCT, rather than tendering, simply extends existing primary medical services contracts (i.e. extending GP-led care), you may wish to present a proposal to the GP practice/s to provide certain elements of the extended service – again the NPA PBC templates may be an appropriate format, or at least provide a structure with which you can order your thoughts.

Have you been asked to make a verbal presentation, either before, with or after the written bid is submitted? The NPA has produced a set of PBC powerpoint slides, which may be useful if you are formally pitching to an audience with currently little understanding of community pharmacy's potential. The slides are available to NPA members by contacting nhsdev@npa.co.uk

Win £6,000 in C+D's pharmacy design awards.
Download an entry form at:
www.dotpharmacy.com

New services at a price

Services well advanced but workloads and GP relationships a concern

Zoe Smeaton

Pharmacies in England and Wales are providing new services across all three tiers of the 2005 national contract. But more commitment and investment is required in some areas, according to a major national evaluation.

The study, commissioned by the Pharmacy Practice Research Trust, found the implementation of essential services was well advanced or complete in most pharmacies. Three-quarters now have a private consultation room, the study of 31 primary care organisation's revealed.

Over 60 per cent of pharmacies now provide medicines use reviews or prescription intervention, and almost 90 per cent provide at least one enhanced service such as smoking cessation services.

However, although the pharmacists surveyed valued the improved patient relationships brought about by the contract, a quarter said it made them less likely to stay in the profession due to an increase in workload.

Another area for concern was the fact that the contract seemed to have done little in practice to improve the working relationship between pharmacists and GPs. More than 80 per cent of pharmacists said there had been little or no change in their contact with GPs since the new contract. And GPs perceived a gap between what they wanted pharmacists to concentrate on in MURs and what pharmacists were providing.

Lead researcher Professor Alison Blenkinsopp said it was down to individual pharmacists to try to improve this situation. "We think community pharmacists now have to, as the Americans would say, step up the play and actually go to bat on this collaboration with the GPs, so making more contact with GPs locally."

New stoma supply plan?

The Department of Health has unveiled plans to extend the home delivery service for stoma appliances to include incontinence items, and to increase their additional dispensing fee. However, it proposes reducing reimbursement for the items.

The home delivery fee has been increased 63p to £3.23 per item, and the service will now include catheters and incontinence prescription items.

Under the proposals, specialist nurse visits will also now apply to all three item categories and contractors will receive £40 per visit, up to a limit of one visit for every 70 appliances dispensed in the financial year.

However, the DH wants to save the NHS £25 million by reclassifying the products and cutting reimbursement, a move it says reflects the lower industry costs.

The proposals are open to consultation until November 29. **JR**

James Powell, owner of mobile pharmacy company The Medicine Man, spent the last weekend of the festival season with party-goers at The Isle of Wight's Festival. Common complaints included headaches, blisters and heartburn, while other customers had left their toothbrushes and contraceptive pills at home. Mr Powell said: "People say it must be great to work at a festival, but it's still work." But he admits that the characters he meets and the outfits he sees do keep him entertained

News in brief

NHS colleague access

Pharmacists will soon be given email access to over one million NHS colleagues under government plans. Rolling out NHSmail will "underline" pharmacists as part of the NHS family, health minister Ben Bradshaw told the British Pharmaceutical Conference.

Update question error

Question five of module 1414 has been excluded from the marking because of an error in which a key word was omitted. C+D apologises for any inconvenience caused.

Numark web launch

Numark has revamped its members only and consumer websites in a bid to boost business support for independent pharmacists. Members can now access DIY SOPs, rebate details and staff training aids from www.numark.net. The public site, www.numarkpharmacists.com, directs consumers to their nearest Numark pharmacy using Google maps.

Expert working group

Professor Roger Walker, a pharmacist from the National Public Health Service for Wales, will lead the MHRA's expert working group charged with introducing tighter sales controls on pseudopephedrine medicines.

NCSO update

The Department of Health and the National Assembly for Wales have agreed to allow NCSO endorsements for the following items for September 2007 prescriptions: diamorphine 5mg, 100mg and 500mg ampoules; mefanamic acid 250mg capsules.

Platinum Design Awards 2008

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Reference: 1. MIMS, June 2007.

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Date of preparation: June 2007

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www.dotpharmacy.com/upmain.html

Inquiry to find new RPSGB

An independent inquiry to find out what pharmacists want from the professional body that will succeed the Royal Pharmaceutical Society will get under way mid-September.

"Its success will depend on the involvement and engagement of all pharmacists," its chairman, Nigel Clarke, told the British Pharmaceutical Conference in Manchester on Monday.

He promised a transparent process. The inquiry will be web-focused, with a website and email address in operation within a fortnight. A draft consultation document will be posted on the site by early November, along with all evidence submitted, both verbal and written (see panel below).

The independent inquiry into the options for a professional body for pharmacy was commissioned by the RPSGB as a consequence of the government's decision to move the Society's regulatory functions to a General Pharmaceutical Council.

The timing of the consultation – the busiest time of the year for community pharmacists – and its short duration were criticised by Graeme Millar, a former chair of the Scottish Pharmaceutical General Council.

"Government consultations run for 12 weeks. They should be extended," he said.

Mr Clarke responded that he was constrained by the timescale in which the Society had asked him to report. **PG**

The inquiry timetable – how you can feed in you views

- **By mid-September**
  Website and email addresses in operation, and announcement of inquiry's panel of advisers
- **End October – mid-November**
  Draft consultation available on website. All evidence submitted posted on website
- **November – December**
  Public meetings nationwide, key stakeholders invited to evidence sessions in London, Edinburgh and Cardiff
- **December 31**
  Closing date for submissions to consultation process
- **January – February 2008**
  Writing final report
- **March 2008**
  Deliver report to RPSGB

Confusion over names fuels dispensing errors

Similarities in drug names and packaging cause high percentage of mistakes

Zoe Smeaton

Drug name and packaging similarities still play a role in many dispensing errors, the Pharmacists' Defence Association (PDA) has found.

In an analysis of 434 PDA error reports from 2004 to 2007, the association found that nearly 40 per cent of errors involved the wrong item being dispensed. In two-thirds of those cases, the drug dispensed started with the same letter of the alphabet as the intended drug, and in half of the cases there were some perceived packaging similarities.

Certain drugs are more likely to trigger a dispensing error, the PDA research claimed. Six drugs accounted for 35 per cent of incidents where the wrong medicine was dispensed, the research revealed [see box]. John Murphy, director of the PDA, said he found this "staggering".

"Can you imagine what we could do in terms of cutting down error rates if we could address some of those issues? I think the big thing [for pharmacists] is to be aware of those medicines that are causing the most errors, and make those the things that give them a shock when they see them," he said.

The PDA also found that in half of all wrong item and wrong strength errors, pharmacists felt there were staff difficulties; and that pre-labelling errors were a "growing malaise".

Mr Murphy advised pharmacists to pay close attention to staffing shortages and not accept practises that they felt increased risk.

What triggers dispensing errors?
haveyoursay@cmpmedica.com

Drugs most commonly linked to 'wrong drug' dispensing incidents:

12 per cent of cases: atenolol amitryptiline and allopurinol
7 per cent: amlodipine, amiloride, amiodarine
6 per cent: insulin
3.5 per cent: rabeprazole, rovustatin, ropinirole, risperidone
3.5 per cent: chloramphenicol eye/ear drops
3 per cent: trazadone and tramadol

Union status for PDA

Pharmacists are to have a trade union from January 2008 after the Pharmacist's Defence Association confirmed plans to form a union for employees, locums and pre-reg students.

Improving pay and working terms for members will be key goals for the new PDA Union, John Murphy, PDA director, told C+D.

Gaining official union status will also allow the PDA to represent members in disciplinary hearings with their employers, Mr Murphy said.

He added: "We want to get involved in representing pharmacists in employment disputes. Also strategically we want to look at renumeration, workload and working environment, particularly with locums."

Union membership will be free to PDA members. Non members will pay an annual registration fee. **MG**

There at last after three days on the road! The 70 cyclists who took part in the annual Rowlands London to Paris Bike Ride in aid of Great Ormond Street Children's Hospital gathered under the Eiffel Tower in Paris last Monday (September 3). The ride was led by Phoenix CEO Paul Smith and co-ordinated by Rowlands estates manager Mike Blakeman. The event, now in its seventh year, attracted a record number

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TENA *Lady*	Pip code	Box contents
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ULTRA MINI	272-5133	10 X 28 (280)
ULTRA MINI PLUS	325-4661	6 X 24 (144)
MINI	277-8215	10 X 20 (200)
MINI PLUS	280-6859	10 X 16 (160)
NORMAL	259-4448	6 X 12 (72)
EXTRA	259-4455	6 X 10 (60)
EXTRA PLUS	304-1639	6 X 8 (48)

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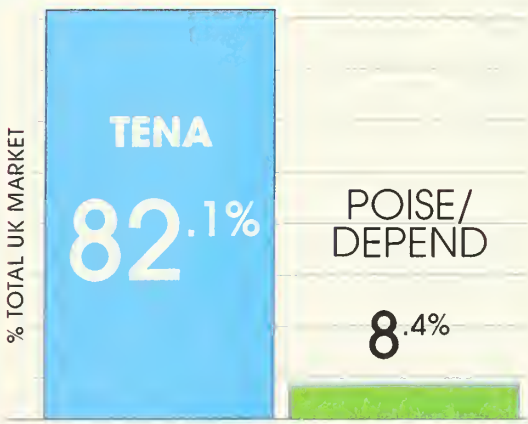
UK sales of bladder weakness products 2007



(Source: IRI Value Sales 4 w/e 16 June 2007)

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At last week's UniChem conference in Barbados, contracts, wholesaling and business opportunities were high on the agenda. **Tom Hawkins** reports

Pharmacy's shifting sands

Start doing MURs

Kirit Patel, chief executive of Day Lewis, fired up the second day of business with a motivational speech about the essential elements involved in growing a pharmacy business. Mr Patel highlighted the importance of hitting MUR targets to boost income.

"That [MUR income] equates to £500 cash takings in the till at the end of the day. Think how difficult it is to get £500 in the till and how easy it is to do an MUR," he said.

Howard Hopkins of Ceuta Healthcare said there was 'skew' from multiples behind the rising MUR figures. He urged independents to concentrate on the basics to get up and running with MURs and ensure they are represented in equal measure.

Services

Kamal Mahasuria of Altwood Pharmacy in Maidenhead gave a frank account of how he became disillusioned with his career in pharmacy and was at the brink of leaving the profession when he decided to turn his dispensing business around by focusing on clinical services.

He now runs an asthma and COPD clinic and emphasised the importance of targeting commissioners with the appropriate service proposals in order to secure funding.

Mr Mahasuria said: "As pharmacists, we are more than capable of dealing with a lot of the ailments that currently present at GP practices. What we have lacked in the past is the mechanism to treat these patients – but I feel that's changing now."

This point was exemplified by Ash Soni of Copes Pharmacy who discussed the opportunities presented by independent prescribing and the job it has in boosting pharmacy's role in healthcare.

He said: "Prescribing offers an opportunity to speed the process by improving recognition both by fellow healthcare professionals but also the public."

Information technology

Simon Driver, managing director of software provider CegedimRx, covered off the complexities of the electronic transmission of prescriptions being rolled out across the UK.

Despite the imminent implementation of EPS Release 2, Mr Driver said the number of pharmacies not even connected to the N3 spine was as high as 40 per cent and that these contractors were putting their business at "an unacceptable but avoidable risk".

He added that the demands of government programmes, such as Connecting for Health, mean software suppliers are burdened with extra costs for development and support and that these could ultimately be passed on to pharmacists.

Distribution changes

Distribution is one of the fastest changing sectors in pharmacy and the traditional role played by wholesalers and pharmacists is under threat, delegates heard.

Conference chairman Mike Smith said the direct to patient market is predicted to grow from between £500m and £800m today to £2,000m by 2010.

A proposal

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Build your OTC business

Trevor Gore of Reckitt Benckiser entertained the crowd with a humourous presentation that made a serious point about why independents are losing OTC sales to supermarkets.

Pharmacy customers, he says, will make emotional purchases based on a product's benefits but pharmacists often focus too heavily on a product's features. "It's not about ingredients. That's your thought process. They don't care," he said.

Mr Gore's point was emphasised by Rob Yateman of the recently acquired Johnson&Johnson, who said pharmacists were in a prime position to benefit from the higher return offered by OTC sales and that they should exploit their key selling point of convenience.

"If we don't grasp it, it will be lost and it will be lost to the commoditised grocery arena," he said.

AstraZeneca, Pfizer and Sanofi-aventis all discussed their decisions to alter their distribution models. Mike Isles from Sanofi-aventis said manufacturers faced pressure from government to ensure they distribute efficiently and manage supply chain integrity. He emphasised that the company chose the wholesale channel as the route to achieve these goals in collaboration with pharmacists.

Wholesale and commercial affairs director at Alliance Healthcare Ornella Barra said UniChem will work closely with manufacturers to manage the evolving distribution channel. Third party logistics firms such as DHL, she said, were not suited to the specialist needs of pharmaceutical delivery.

"It's easier to deliver Coca-cola or other products but for pharmacy products – healthcare products – a special know-how is needed."

Paul Forster-Jones, MD of Cordia and OTC Direct, spoke of the growing risk of counterfeit medicines. He said the MHRA should limit wholesale distribution licences to provide a greater safeguard against the growth of counterfeits.

He said: "There are 1,200 companies operating with less than three employees and many of them are sole traders."

Work with Boots

Graham Webster and Colin Stuart of Boots The Chemists had the challenge of discussing the high street multiple's growing role in supporting independent pharmacy.

They acknowledged that independents get frustrated with elements of Boots' strategy, such as its care home dispensing business, but argued that its aim is to compete with grocers and large multiples, not independents.

They added that Boots has stopped active recruitment of pharmacists from UniChem customers and is working on ideas with the wholesaler to help independents promote OTC sales.

UniChem sales director Jeremy Main gave an example of the collaboration between the wholesaler and Boots in the Roche Accu-Check diabetes screening kit within its 'your portfolio2' retail offering, which was sourced through Boots' buying power.

Furthermore, UniChem is finalising a 'virtual chain' package based on Alliance Boots expertise from across Europe. Launched later this year, it will include a dispensing scheme, OTC promotions and business development programmes.

Chilling out: delegates take a break from the business sessions

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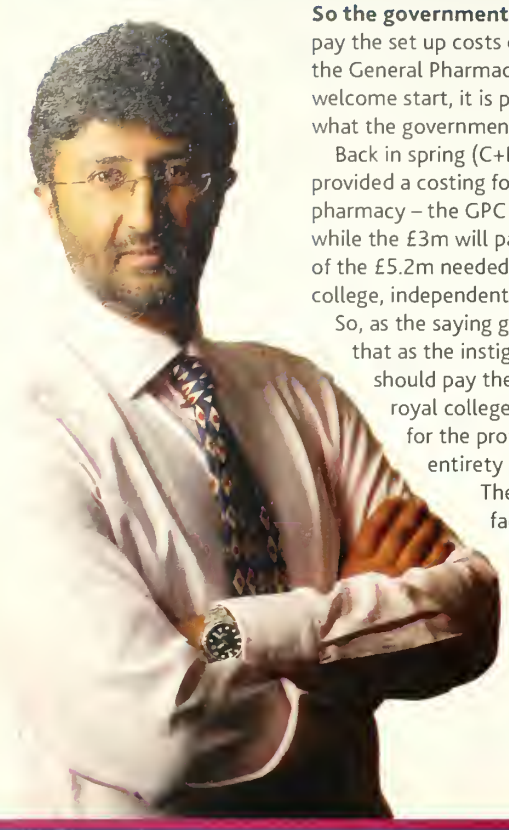
Comment from the editor



So the government is to put £3 million into the pot to pay the set up costs of the new regulator for pharmacy – the General Pharmaceutical Council (GPC). While this is a welcome start, it is perhaps more revealing to look at what the government is not prepared to pay for.

Back in spring (C+D, May 26, p4), government analysts provided a costing for setting up the future structures for pharmacy – the GPC and a royal college-type body – and while the £3m will pay for setting up the GPC, it falls short of the £5.2m needed to set up both the GPC and the college, independently from the RPSGB.

So, as the saying goes, are you bovvered? Do you feel that as the instigator of the upheaval, the government should pay the full £5m? Or do you think that a royal college would offer such a huge opportunity for the profession that we should pay for it in its entirety out of the RPSGB coffers?

The decision is further clouded by the fact that we do not yet know exactly what a royal college will do and whether it could (or should) exist as a separate entity from the RPSGB. Perhaps pharmacy's future should comprise a triumvirate – a regulator, a college of excellence and an organisation to represent members – mirroring the medical profession?

With the government promising further development of pharmacy services, there is a need for a college-type organisation to promote excellence in delivery of those services. But equally with the government seeking to ensure it gets value for money for those services, there is a need for an organisation to ensure pharmacists receive a fair reward for a fair day's work. And while contractors have effective representation, should there be a professional representative body for those at the coalface?

Don't miss the chance to have your say. With the Society announcing the timetable (p8) for its inquiry into what you want from a professional body, the window of opportunity for change will not be open forever.

Gary Paragpuri, editor

> "Do you feel that as the instigator of the upheaval, the government should pay the full £5m?"

Pharmacist in the House

What not to wear

Would pharmacy benefit from a Trinny and Susannah makeover, asks C+D columnist Sandra Gidley

In the present media age, politicians are very image conscious and, although it may not always look like it, they think hard about what they say (John Prescott may well be an exception) and how they look (I am too kind to name and shame).

Having read a recent article about what a pharmacist should wear, it occurred to me that the profession itself was in need of a 'Trinny and Susannah' type makeover.

Anybody who has watched the programme will have realised that T and S are clever girls and work with someone who may not be presenting the best image in the world but has some basic features and qualities that can, relatively easily, be presented in a favourable light.

So how would pharmacy fare in an audition? T and S might see a profession that lacked confidence and didn't always sell itself to its best advantage. A profession that was happiest in its own comfort zone. They would also be acutely aware that here was a profession with a doctors or nurses, conscientious and with an amazing safety record and attention to detail. Individual practitioners are usually highly regarded by their patients and customers. In other words we have absolutely first class material to work with and the task is made easier by the fact that, at a strategic level, the profession is underselling itself.

It's a little more complicated than that though because there is a disconnection between those who see themselves as leaders and those at the coalface who have to deliver the goods. So, do T and S have to wreak some fantastic change on grassroots pharmacists as well as pharmacy's leaders?

For pharmacy to shine I believe T and S would act at both levels. Pharmacy's leaders need an injection (some would prefer another route of administration) of whatever hormone is required to stop being ever so polite with the Department of Health and make it crystal clear that the government's regulatory changes

which has always served the public well. We also need leaders who challenge and promote the profession at every opportunity.

At grassroots level T and S would invigorate the "can do" gene and

of their comfort zones. They would engage with current activity and challenge the leadership but, more importantly, take the time to make a strong case locally for the improved benefits they could bring to patients.

If you don't think that pharmacy is in need of a makeover then just consider this. How often is a representative of pharmacy on the news, compared to a representative of the BMA or the RCN? How often are local services not commissioned because pharmacy is too easy to dismiss? And how often have you moaned about the above and not done anything about it?

So, if T and S were really clever, they would ensure that all pharmacists found a way to work together instead of blaming the small cohort who actually try very hard to make a difference. By working together in a co-ordinated way there will be no need for a makeover so let's not squabble internally. Let's show the world we mean business...

Sandra Gidley, Lib Dem MP and shadow health spokesperson

Xrayser

Xrayser C+D

Where's the mystery?

I'm not scared of mystery shoppers. I am upset, however that, despite being a member of a well regulated and respected profession, I feel my integrity is being called into question (C+D, September 8, p4).

Mystery shoppers are all well and good for shops selling alcohol or cigarettes to under-age children, for example. But there is no point sending them to a pharmacy unless you're desperate for material for a scare story. Off-licences are not run by professional people and if they sell alcohol to under-18s they are breaking the law. They should be monitored because anyone breaking the law should be taken to task.

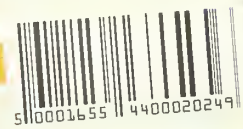
But so what if I decide to sell two packs of Sudafed to a patient based on sound professional reasoning? What will the MHRA do about it – strike me off? And hasn't Numark got better things to do?

I am fully informed about the issues surrounding pseudoephedrine and my staff are all well trained. We will adhere to the new recommendations in general because I appreciate the wider implications of the situation we find ourselves in. But if a patient is taking a pseudoephedrine product regularly on the advice of their GP, for example, then I will not hesitate to sell them two packs at once.

I can only make myself look stupid if I become a complete jobsworth in the face of common sense. I would lose professional respect from both other

24 tablets inside

C+D



healthcare professionals and patients, who would simply be forced to return the following day or, worse still, purchase additional supplies from another pharmacy.

Everyone who walks into the pharmacy is treated the same, mystery shopper or not. But of course someone unknown to me will never get hold of two packs. The only pharmacists who need worry about mystery shoppers are the ones who already know they're not doing their job properly.

The reason that all this blew up in the first place was to try and stop the illegal production of crystal meth from OTC pseudoephedrine. Even if the MHRA finds the odd pharmacy not sticking to its guidelines, it doesn't mean the country will be over-run by crystal meth addicts. I would have thought the MHRA would have been better spending its time looking out for illegal production rather than monitoring potential sources of raw material.

I can't help thinking that the whole issue has become too political and lost sight of reality. The MHRA wanted to make pseudoephedrine a POM and it's used to getting what it wants. It's had its nose put out of joint by this apparent failure and seems dead set on making a point about how right and powerful it is. What a waste of time.

Sun, sea and sand – no thanks

It sounds like all doom and gloom at the UniChem convention (C+D, September 8, p32). Apparently we're not providing enough enhanced services, there won't be any money in dispensing in future, we're about to have our credibility ripped apart by a Which? report, we may lose our place in the supply chain, and the supermarkets are ever more threatening.

I'm just glad I've been tied to the dispensing bench, looking out at the rain and working my socks off, but at least having a laugh with customers and staff. X Pharmacy sounds like a much jollier place to be this week than Barbados beach.

Xrayser C+D

24 tablets inside

LPC Inbox

Think not what can the LPC do for me...

Having recently attended a gathering of community pharmacists, I thought I would reflect on an informal debate that I got drawn into. This arose on the back of one of the formal sessions where the role and effectiveness of LPCs was raised. I questioned how many of the pharmacists around the room were members of their LPC; a few were, some actively, but many just attended or were not members.

Perhaps therein lies part of the current problem within community pharmacy which is reflected in the external view that other healthcare professionals, commissioners and NHS managers have of us. LPCs are often under-resourced and under-skilled for the new world of the NHS as a commissioning body; hence they cannot afford to have

> "The outcome could be disastrous if funding is based on quality"

bums on seats whether they be independent or CCA representatives, something that both should take seriously.

Active participation within an appropriate LPC governance framework is key to an equitable solution for our profession as a provider within the primary care team. The alternative outcome could be disastrous if the often muted move towards a quality service based funding framework is enforced by the Department.

So if you have put your hand up to be part of an LPC, ask yourself whether you actively contribute to its core function and purpose. If you are not on an LPC, but are not content with the current outcomes, don't whinge from the outside, get involved and help them make a difference.

Written by an LPC officer

Pharmacy Champions

Amanda Jones, of Village Pharmacy in Harlington, Middlesex, took part in an eczema education project

My employer was approached by a medical research company, Clinimatrix, to help set up a project to measure the effects a **pharmacist intervention** could have on childhood eczema. The project was funded by Stiefel laboratories.

I underwent training by a specialist eczema nurse on how to identify suitable candidates, how to fill in patient questionnaires and what advice to give the parents or carers.

We looked out for children with prescriptions for emollients – particularly bath emollients because they're the ones that would benefit the most, rather than just the creams.

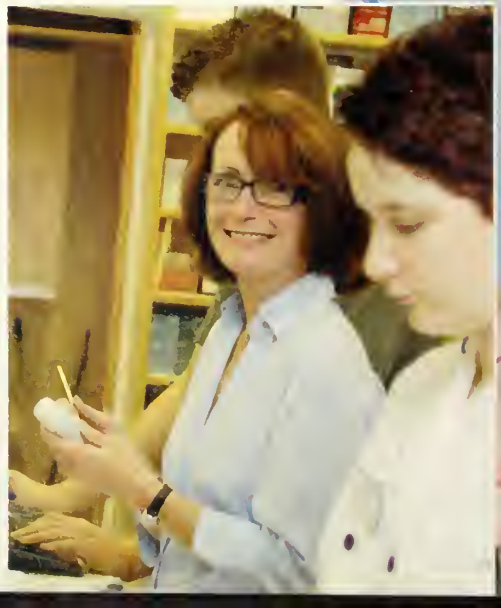
We asked the parents to fill in a quick questionnaire, to find out what they didn't know. Then we sat down with the parents and told them the things they didn't know. They're given these bath oils and emollients on prescription without any directions on how to use them. Before the project, 20 per cent of parents had previously been shown how to apply emollient creams by a GP or nurse, **but only 10 per cent** were actually applying them **correctly**.

So we asked them how they used them to get an idea if they were using them effectively, and then we gave them advice on how they should be using them. Very often people are scared of using things and were under-using if anything, and not getting the benefits.

It was as simple as that. The advice sessions were followed up with a phone call to find out how patients had got on since.

The **high point** of the service was seeing what a difference a simple pharmacy intervention and a bit of education could make in real terms. We had a lot of **positive feedback** from the parents.

The project won a Royal Pharmaceutical Society award which was fantastic. I am keen to build on that and make our pharmacies **centres of excellence** for eczema. The project made such a difference it would be good to roll it out to other people. National Eczema Week starts on September 16, so that would be an ideal time to start raising awareness. There are more eczema sufferers that would benefit from a pharmacist intervention to promote compliance with their



Under the white coat

- The **best thing about my job** is the variety and challenges it brings. I am involved in prison health and am a level three smoking cessation advisor. I am particularly interested in clinical governance – especially staff training and motivation. Since the project all aspects of dermatology interest me as well.
- When I was little I wanted to be a primary **school teacher** but I don't have any regrets about my change of mind.
- If I wasn't a pharmacist I could see myself as **an artist** living by the sea.
- My scariest moment as a pharmacist was being **robbed at knifepoint** in my previous job (it wasn't the reason I left!).

Out of hours

- My **guilty pleasures** are a hot bath, a glass of wine, a good book or a long walk.
- If they class as items, the things I would **rescue from my burning house** would be the two children and the cat. Otherwise, my jewellery box, photo collection and handbag.
- My ideal dinner party guests would be someone amusing and articulate like **Jonathan Ross**, someone entertaining like Derren Brown (the illusionist), and a woman with opinions or history such as Germaine Greer or **the Queen.**
- My dream date would be Dr Luka, the **gorgeous doctor** in television drama ER.

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Imigran Recovery 50 mg Tablets (sumatriptan) Product Information. Uses: Acute relief of migraine attacks. Ensure clear diagnosis. **Dosage**: *Adults 18-65 years only:* 50 mg as soon as possible after onset of migraine headache. Repeat dose ≥ 2 hours after first if symptoms recur. Do not take second tablet if no response to first. **Contraindications**: Prophylaxis. Hypersensitivity to constituents or sulphonamides; concurrent treatment with MAOIs, ergots, other triptans; myocardial infarction, ischaemic heart disease, symptoms/signs consistent with ischaemic heart disease, coronary vasospasm (Prinzmetal's angina), arrhythmias, peripheral vascular disease; stroke or transient ischaemic attack, hypertension; hepatic or renal impairment; history of seizures, lowered seizure threshold; hemiplegic, basilar or ophthalamoplegic migraine. **Precautions**: First migraine after age 50, assess risk factors for cardiovascular disease, typical headache > 24 hours, atypical symptoms, taking combined oral contraceptive pill, pregnancy or breast feeding. **Interactions**: MAOIs, ergots, SSRIs, SNRIs, tricyclic antidepressants, St John's wort. **Side effects**: Common: pain, heat, cold, heaviness, pressure or tightness affecting any part including chest and throat; may be intense, usually transient. Dizziness, drowsiness, sensory disturbance including paraesthesia and hypoaesthesia; nausea, vomiting. Feelings of weakness, fatigue. Very rare: hypersensitivity reactions, seizures, tremor, dystonia, nystagmus, scotoma; visual disturbances; cardiovascular disturbances including bradycardia, tachycardia, palpitations, arrhythmias, ischaemias, coronary artery vasospasm, angina, myocardial infarction, hypotension, Raynaud's, ischaemic colitis. **Legal category** P. **Product licence number** PL 00071/0455 **Product licence holder**: GlaxoSmithKline Consumer Healthcare, Brentford, TW8 9GS, U.K. **Package quantity and RSP** 2 tablets £7.99. **Date of revision** July 2007. **Imigran** is a registered trade mark of the GlaxoSmithKline group of companies.

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References: 1. Goadsby PJ, Lipton RB, Ferrari MD. N Engl J Med 2002; **346**(4): 257-270. 2. Humphrey PPA. Cephalalgia 2001; **21** Suppl 1: 2-5. 3. Landy S, Savani N, Shackelford S *et al.* Int J Clinical Practice 2004; **58**(10): 913-919. 4. Winner P, Mannix LK, Putnam DG *et al.* Mayo Clin Proc 2003; **78**(10): 1214-1222.

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Clinical News

A Practical Approach...

Update Pharmacy sales assistant Madeleine knocks on the office door of pharmacist David Spencer.

"Do you mind if I disturb you for a minute?" says Madeleine. "My boyfriend Will asked me to ask you for some advice."

"That's OK," replies David. "How can I help?"

"Well, Will's pretty fit and plays plenty of sport. He's in his rugby club first team and might be in the county tennis team next season – but he's worried about arthritis. You see, his father's got it, and his aunt and uncle. He's got no problems at the moment, except he gets stiff in his lower back sometimes. He says his family all take glucosamine and find it very helpful. His rugby club physio says his back stiffness is muscular, but he's got nothing to lose by taking glucosamine to ward off arthritis in later life, and that he should also take chondroitin. But Will's a bit wary because he often gets bad reactions to medicines, and doesn't want to take anything that might upset him. I've looked at what we've got on the shelves, but the information is pretty vague. So, what do you think?"

Questions

1. What are glucosamine and chondroitin and what do they do?
2. What are they used for and how effective are they?
3. Would they be of any use to Will?
4. Is Will likely to suffer any adverse effects if he takes them?

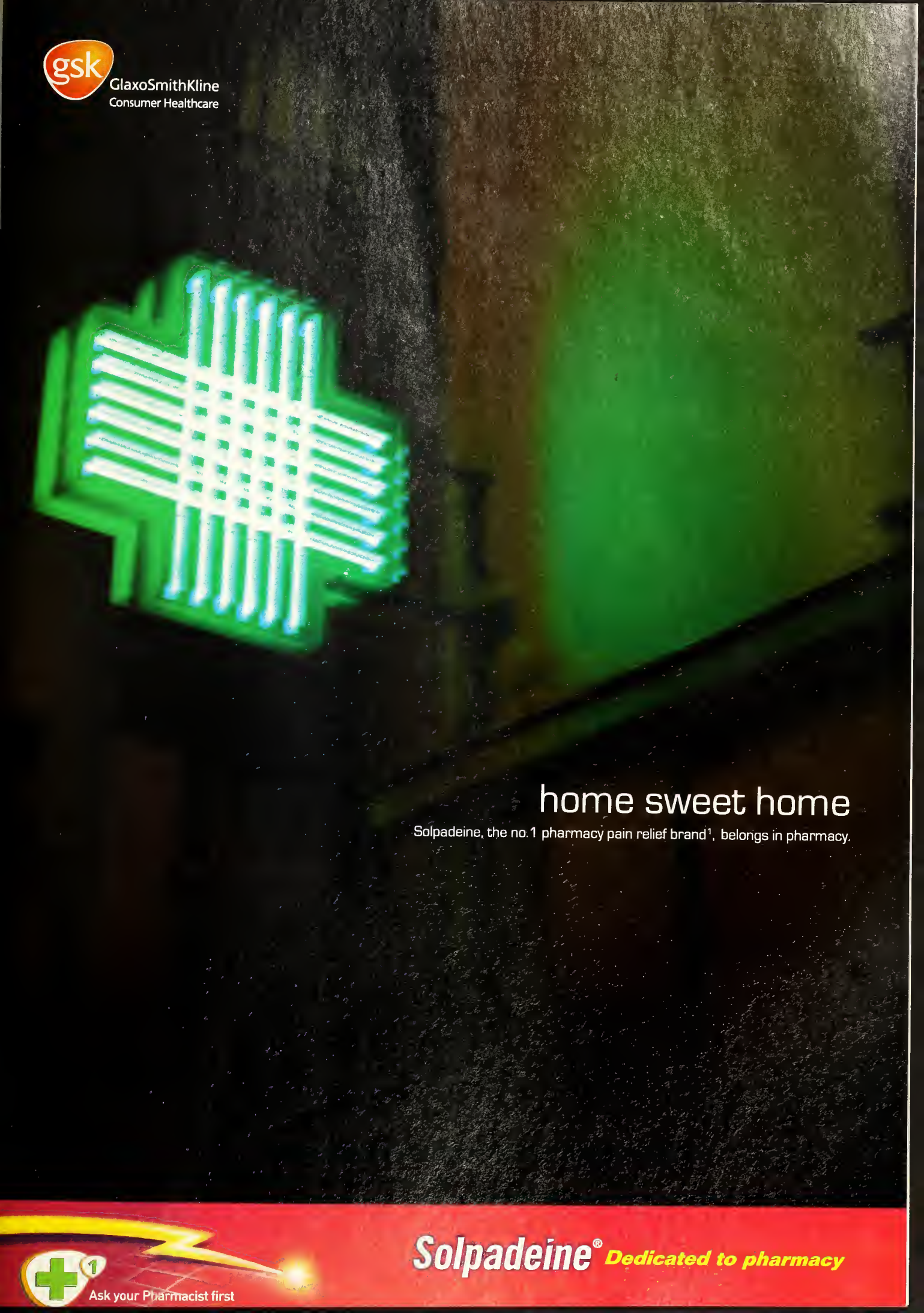
CPD

This article can help in the following CPD competencies: C1f, C2a.
See www.tinyurl.com/194zu

A Practical Approach... this week's answers

1. They are both natural physiological compounds, necessary for maintaining the elasticity, strength and resilience of cartilage.
2. They are used for the treatment of osteoarthritis, relatively common from middle age onwards, characterised by degenerative and sometimes hypertrophic changes in bone and cartilage of joints, resulting in wearing down and distortion of bone at joints, with associated pain. There is a genetic component in some forms of the disease. Two recent systematic reviews of clinical trials[1,2] have concluded that glucosamine and chondroitin, either alone or in combination, are little or no more effective in the treatment of pain and functional impairment in osteoarthritis than placebo.
3. There is no evidence that they have a prophylactic effect, so taking them is unlikely to prevent Will developing osteoarthritis in later life. As they are indicated for osteoarthritis, they are unlikely to help Will's back stiffness.
4. Side effects are no greater than with placebo. They are mostly gastrointestinal, reduced by taking glucosamine with food, and some people may note a slight tingling in their joints.

References
1 Towheed TE, et al. Glucosamine therapy for treating osteoarthritis. Cochrane Database of Systematic Reviews 2005, Issue 2.
2 Clegg DO, et al. Glucosamine, chondroitin sulfate, and the two in combination for painful knee osteo-arthritis. N Engl J Med. 2006 ;354:795-808.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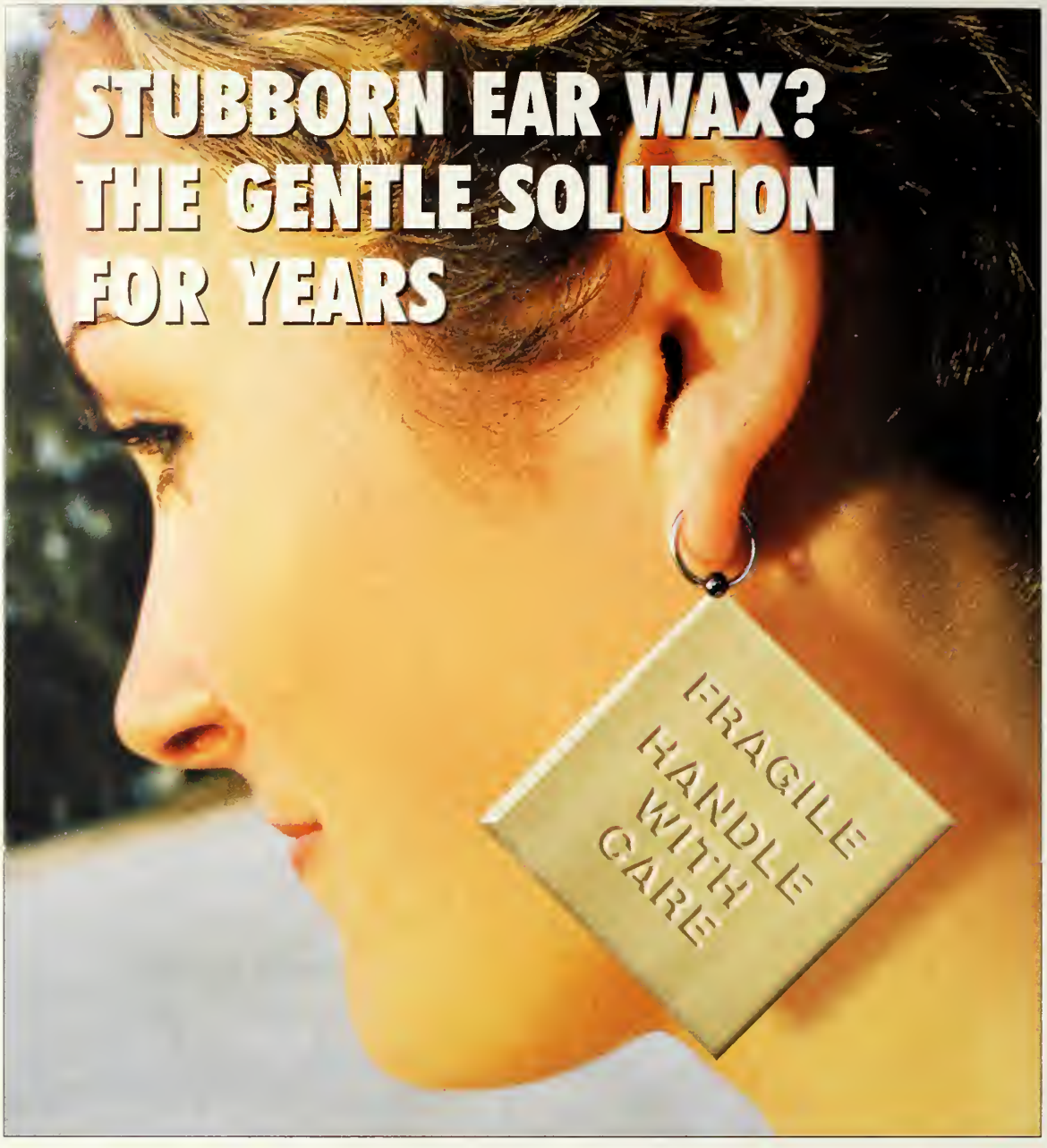
CERUMOL. Product licence held by Laboratories for Applied Biology Ltd., 91 Amhurst Park, London N16 5DR. **Presentation:** A clear oily preparation containing: Arachis (Peanut) oil BP 57.3% w/v, Chlorobutanol BP 5.0% w/v. **Uses:** Occlusion or partial occlusion of external auditory meatus by either a collection of soft wax or a harder wax plug. **Dosage and administration:** *At home:* With the head inclined, 5 drops are put into the ear. This may cause a harmless tingling sensation. A plug of cotton wool moistened with Cerumol should then be applied to retain the liquid. One hour later or the next morning the plug is removed. The procedure is repeated twice a day for three days; the loosened wax may then come out on its own, making syringing unnecessary. If any wax remains the doctor should be consulted so that syringing of the softened residue may be carried out. *At the surgery:* If there has been no prior treatment with Cerumol, 5 drops are instilled as described above and left for at least 20 minutes. Then syringing may be employed, or the doctor may use a probe, carefully ensuring that the wax is not pushed further in. **Contra-indications, warnings, etc:** Otitis externa, seborrhoeic dermatitis, eczema affecting the outer ear and perforated ear drum. Cerumol contains Arachis oil (peanut oil) and should not be taken by patients known to be allergic to peanut. As there is a possible relationship between allergy to peanut and allergy to soya, patients with soya allergy should also avoid Cerumol. *Use in pregnancy:* No side effects have been reported. *Other special warnings:* Not to be taken internally. The patient should not use the drops for more than three days without consulting a doctor. *Overdosage:* As the product is applied topically, overdosage as such is not possible. In the case of accidental ingestion, the amounts of the majority of ingredients in the 11ml bottle are too small to give rise to toxic effects. The 550mg of chlorobutanol in the whole bottle might cause excessive sedation in a child. **Pharmaceutical precautions:** No special storage precautions. **Price:** £3.08 (Retail cost) for 11ml vial with separate dropper. **Legal category:** P. **Product Licence Number:** 00118/0013R. **Further information from:** Laboratories for Applied Biology Ltd., 91 Amhurst Park, London N16 5DR. Tel: 020 8800 2252.

CD/PT/OTC 01/07



For many years now, Cerumol has been coming to the aid of people with problems caused by excessive ear wax.

When wax builds up in the ears and especially when it becomes hard and impacted, deafness, ringing in the ears and earache can follow.

Cerumol's unique arachis oil formula gently and effectively penetrates deep into the ear to soften and loosen the wax. Often, the impacted ear wax will be softened enough to make syringing unnecessary.

It's no wonder then that this formulation has been the ear wax treatment most widely prescribed by GPs up and down the country.

And it's available only from pharmacies.

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Arachis oil 57% and Chlorobutanol 5%

Penetrates deep to ease out ear wax

Further information is available from: Laboratories for Applied Biology Ltd., 91 Amhurst Park, London N16 5DR. Tel: 020 8800 2252. Cerumol® is a registered trade mark.

C+D Clinical

Thyroid problems

The signs, symptoms and drug treatment of hyper- and hypothyroidism

Key points

- Antithyroid drugs take four to eight weeks to have an effect, so beta-blockers are often also prescribed to control symptoms of hyperthyroidism until the patient becomes euthyroid.
- It is essential that all patients taking antithyroid drugs are aware of the rare possibility of agranulocytosis.
- Levothyroxine tablets should be taken on an empty stomach before breakfast.
- All patients who are stable on levothyroxine require at least annual measurement of serum TSH.
- The effects of amiodarone on thyroid function should be monitored every six months; similarly six- to 12-monthly monitoring of lithium is recommended.

Claire Jones MRPharmS

Your pre-reg is concerned that he is dispensing a prescription for both carbimazole and levothyroxine tablets to a patient who has been recently diagnosed with hyperthyroidism. How do you explain this to him?

Which common and rare side effects would you expect your pre-reg to counsel this patient on?

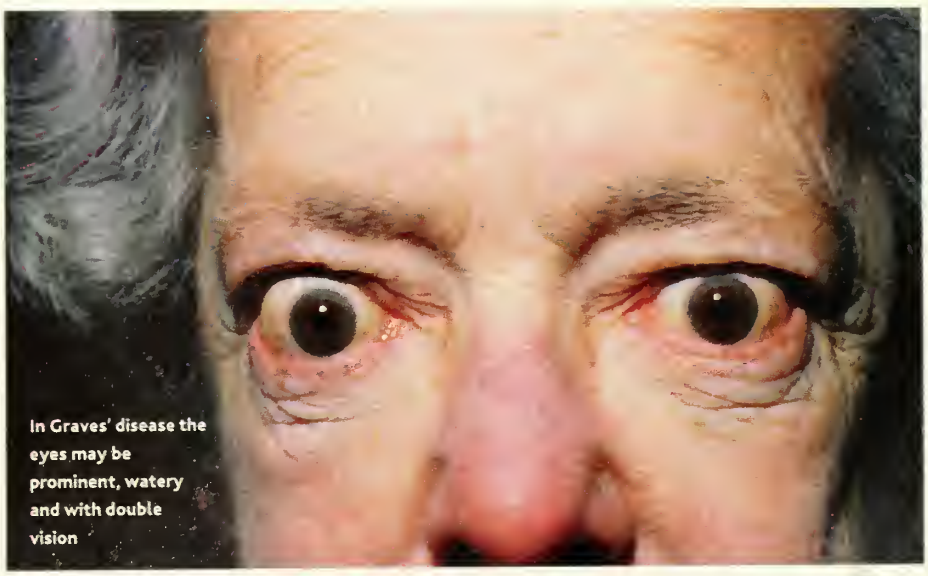
Reflect

What are the signs and symptoms of an underactive thyroid? What are the normal ranges of TSH, T3 and T4? What does euthyroid mean? What is a block-replace regimen?

Plan

This article covers the causes, signs and symptoms and drug treatment of hypo- and hyperthyroidism.

CPD This article can help in the following CPD competencies: C1c, C3e, C4k. See www.tinyurl.com/194zu



In Graves' disease the eyes may be prominent, watery and with double vision

Hyperthyroidism

Hyperthyroidism occurs when the thyroid gland in the neck makes too much of the thyroid hormones, thyroxine and tri-iodothyronine. This causes many of the body's functions to accelerate.

Symptoms include:

- being restless, nervous, emotional, irritable, sleeping poorly and 'always on the go'
- tremor of the hands
- losing weight despite an increased appetite
- palpitations
- sweating and a dislike of heat
- diarrhoea
- shortness of breath
- skin problems such as hair thinning and itch
- menstrual changes – often the periods become very light or infrequent
- increased thirst
- tiredness and muscle weakness may be a feature.

Most people with hyperthyroidism do not have all the symptoms, but a combination of two or more is common. Symptoms usually develop slowly over several weeks.

How is it diagnosed?

One or both of the following may be measured:

- **Thyroid-stimulating hormone (TSH).** This hormone is synthesised in the pituitary gland and stimulates the thyroid gland to make the thyroid hormones. If the level of thyroid hormones in the blood is high, then the pituitary releases less TSH. Therefore, a low level of TSH means the thyroid gland is overactive.
- **Free thyroxine (T4)/tri-iodothyronine (T3).** A high level of free T4 and free T3 confirms hyperthyroidism.
- A person is euthyroid when thyroid function and hormone levels are normal (ie TSH less than 6mU/L, free T4 9-25pmol/L, free T3 3-9pmol/L).

The College of Pharmacy Practice

This course (module 1416), in association with multiple choice questions being published in C+D October 6, provides one hour's continuing education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To download an article from C+D's Pharmacy Update series, visit the archive at:
www.dotpharmacy.com/upmain.html

Hyperthyroidism can be differentiated into overt and subclinical:
- Subclinical is diagnosed when the TSH level is suppressed, with free T4 and T3 levels within the normal reference range, in an asymptomatic person.
- Overt hyperthyroidism is diagnosed when the TSH level is suppressed, with free T4 and/or T3 levels above the normal reference range, in a person with symptoms of hyperthyroidism. This is the condition that is routinely treated with antithyroid drugs.

What are the causes?

Graves' disease is the commonest cause. It can occur at any age, but is most common in women aged 20 to 40. It is an autoimmune disease: antibodies directed against the TSH receptor stimulate the thyroid to make excess thyroid hormones.

The thyroid gland commonly enlarges, which causes a swelling in the neck (goitre). Patients' eyes may seem to be pushed forward and look more prominent (proptosis), leading to watering of the eyes and double vision.

Other causes include drug-induced hyperthyroidism (eg amiodarone and lithium). Six-monthly monitoring for the effects of amiodarone on thyroid function should be performed, with six to 12-monthly monitoring for the effects of lithium.

Drug treatments

All people with hyperthyroidism should be referred to an endocrinologist. If the patient has features of hyperthyroidism, treatment may be initiated in primary care while waiting for the specialist assessment:
- Beta-blockers are first choice unless contraindicated. They reduce the risk of tachyarrhythmias and give symptomatic relief (eg for anxiety and tremor).

antithyroid drugs may be initiated at a low dose in primary care in certain circumstances:
- if beta-blockers are contraindicated
- in addition to beta-blockers if features of hyperthyroidism are marked.

Antithyroid drugs inhibit thyroid hormone synthesis. Initial doses of carbimazole range from 15 to 40mg once a day, and initial doses of propylthiouracil range from 200 to 400mg per day in divided doses. Therapy is continued at the initial dose for four to eight weeks until the person becomes euthyroid (based on the free T4 level).

There are then two options:
- Titration regimen — the dose is gradually reduced to a maintenance dose of 5 to 15mg per day for carbimazole or 50 to 150mg per day for propylthiouracil to try to achieve a euthyroid state.
- Block-replace regimen — it can be difficult to judge just the right dose of carbimazole, so one option is to deliberately use a high dose to stop the thyroid gland synthesising thyroid hormones, and then to take levothyroxine tablets to achieve the euthyroid state.

Side effects
- Pruritus and rashes are common, but often resolve with continued treatment or by taking an antihistamine. If a treatment change is necessary, changing propylthiouracil to carbimazole (or vice versa) can be effective.
- Agranulocytosis is rare (three per 10,000 patient years of treatment) but, if it does occur, it usually develops within the first three months. Advise patients to seek immediate medical care if they develop a fever, sore throat, mouth ulcers or other symptoms of infection.

Beta-blockers give symptomatic relief (eg for anxiety, palpitations, tachycardia, tremor) and are often used while waiting for antithyroid drugs to achieve the euthyroid state (usually within four to eight weeks).

Propranolol and metoprolol are widely used but, because hepatic metabolism is increased in hyperthyroidism, they need to be given three to four times a day. Atenolol only needs to be taken once a day (as it is mainly excreted by the kidneys) but is not licensed for this use. Larger and more frequent doses may be required because people with hyperthyroidism may be relatively resistant to the effects of beta-blockers.

Monitoring Once a maintenance dose of antithyroid drug has been established, thyroid function tests should be carried out every three months.

Where can pharmacists help?

It is essential that all patients taking antithyroid drugs are aware of the rare possibility of agranulocytosis. Patients should be counselled that these drugs can, rarely, affect the white blood cells that fight infection. If they develop a fever, sore throat, mouth ulcers, or other symptoms of infection while taking carbimazole they should see a doctor urgently for a blood test.

Hyporthyroidism

Hypothyroidism occurs when the thyroid gland does not make enough thyroxine and tri-iodothyronine. This causes many of the body's functions to slow down.

Symptoms commonly include tiredness, weight gain, constipation, aches, feeling cold, dry skin, lifeless hair, fluid retention, mental slowing and depression. Less common symptoms include a hoarse voice, irregular or heavy menstrual periods in women, infertility, loss of sex drive, carpal tunnel syndrome and memory loss or confusion in the elderly.

Symptoms usually develop slowly, and gradually become worse over months or years as the level of thyroid hormones in the body gradually falls.

How is it diagnosed?

One or both of the following may be measured:
- **Thyroid-stimulating hormone (TSH)** This hormone is synthesised in the pituitary gland and stimulates the thyroid gland to make thyroid hormones. If the level of thyroid hormones in the blood is too low, then the pituitary releases more TSH. Therefore, a high level of TSH means the thyroid gland is under-active.
- **Free thyroxine (T4) / tri-iodothyronine (T3)** A low level of free T4 and free T3 confirms hypothyroidism.

Hypothyroidism can be differentiated into overt and subclinical:
- Subclinical hypothyroidism is diagnosed when there are no specific symptoms or signs of thyroid dysfunction but the TSH concentration is above the reference range and the free T4 concentration is in the normal range, confirmed on repeat testing after at least three months. If the TSH concentration is greater than 10mU/L and this finding is confirmed on repeated testing (at least three months later), many experts recommend treatment with levothyroxine.
- Overt hypothyroidism is diagnosed on the basis of characteristic clinical features (described above), with a serum TSH concentration above the normal reference range and a serum-free T4 concentration below the reference range. This condition is routinely treated with levothyroxine tablets.

What are the causes?

The most common cause is an autoimmune disease called autoimmune thyroiditis. This is more common in people with:
- a family history of this condition
- Down's syndrome: hypothyroidism develops in one in three people with Down's syndrome before the age of 25 years
- a personal or family history of other autoimmune disorders, eg vitiligo, type 1 diabetes, and coeliac disease.

Some people with autoimmune thyroiditis also develop a swollen thyroid gland (goitre).

Other causes of hypothyroidism include

side effects of drugs, particularly amiodarone and lithium. Six-monthly monitoring for the effects of amiodarone on thyroid function should be performed, with six to 12-monthly monitoring for lithium.

Drug treatments

Levothyroxine tablets are the treatment of choice for hypothyroidism and levels are titrated in the following way:

- In elderly people and people with a history of ischaemic heart disease, start with a low dose (consider levothyroxine 25 micrograms) and every two to three months titrate up by 25 microgram increments.
- In younger people, start with levothyroxine 50 to 100 micrograms and every two to three months titrate up by 25 to 50microgram increments.
- Measure TSH and free T4 levels two to three months after each change in dose of levothyroxine (ie the frequency of monitoring is usually every two to three months after a change in dose, then yearly once stable).
- Most people have a normal serum TSH concentration on a maintenance dose of 75 to 150 micrograms of levothyroxine daily.

Levothyroxine tablets should be taken on an empty stomach before breakfast. This is because some foods rich in calcium or iron may interfere with the absorption of levothyroxine. Therefore, levothyroxine tablets should not be taken at the same time of day as calcium or iron tablets.

Levothyroxine has a narrow therapeutic range, and small changes in absorption or metabolism can result in clinical or subclinical hypothyroidism or hyperthyroidism.

Particular drug interactions to look for are:

- Calcium, iron and anion-exchange resins reduce absorption of levothyroxine.
- Liver enzyme-inducing drugs (eg carbamazepine, phenytoin, phenobarbital and rifampicin) accelerate metabolism of levothyroxine. Close monitoring and adjustment of the levothyroxine dose are needed when dose changes are made to these medicines.
- People taking concomitant warfarin need careful monitoring. Levothyroxine may increase the anticoagulant effect of warfarin, and the warfarin dose may need to be reduced.

Monitoring All patients who are stable on levothyroxine require at least annual measurement of serum TSH. The general medical services contract includes quality indicators for the production of a register of people with hypothyroidism, and for the percentage of people with hypothyroidism who have had their thyroid function measured in the previous 15 months.

Where can pharmacists help?

- Make sure that patients diagnosed with hypothyroidism know they are entitled to free prescriptions.
- When conducting MURs ensure that patients are taking their levothyroxine tablets in the morning before breakfast.

Further reading can be found at www.dotpharmacy.com/hormones

Continuing Professional Development CPD

Act

- Find out why lithium and amiodarone can cause both hypo- and hyperthyroidism.
- Are there other drugs that have both effects?
- Revise the physiology of the thyroid gland and associated hormones. Pay particular attention to the relationship between thyroid stimulating hormone, the pituitary gland, tri-iodothyronine (T3) and thyroxine (T4).
- Review other treatments for thyroid problems. Possible sites include http://tinyurl.com/ytsnn6 for hypo- and http://tinyurl.com/22kcdt for hyper-thyroidism. You will note that there is an alternative treatment for hyperthyroidism.
- Do you have any patients taking an anti-thyroid drug and levothyroxine? How long do they take this combination? Did they ask why they were taking two 'opposing' drugs? How did you respond? Would your response be different now you have read this article?
- Start a list of drugs that should be taken at a specific time of day or in relation to food intake. This list will become extensive. Do you know of any published lists of this type? Please let C+D know. Levothyroxine has a narrow therapeutic index. A similar list of such drugs may also be of value.
- Ask patients taking levothyroxine when they last had a blood test and record this. What proportion had a test within the past three months?

Evaluate

- The next time you dispense levothyroxine, think about what you need to know about the patient's medical history. Do you know enough? What more should you know? Think about why such information is desirable. Do the same for carbimazole. Can you explain the whys and hows? How is concordance for these patients?

MUR GUIDE TO HORMONES ONLINE

The online version of this article includes a short guide to performing MURs in patients on thyroid medication. See the online version together with previous articles on related topics at http://www.dotpharmacy.com/hormones. Also, we'd like to hear what topics you would like to see in our popular Update series. **Please email your requests to gmatkin@cmpmedica.com**

For a free weekly email alert on C+D's Pharmacy Update series, please register at:
www.dotpharmacy.com/newsbulletins
C+D News bulletin

Distance learning for pharmacists

Pharmacists using Pharmacy Update for continuing education are reminded of the need to test. With the support of Genus Pharmaceuticals, C+D readers can self-test their progress by using the multiple choice question (MCQ) paper to be inserted in the October 6 issue, which will cover this week's CPP-accredited module, together with those in the September 8 and 22 issues.

These will cover:

- Case studies angina (1415)
- Thyroid problems (1416)
- Eye conditions (1417)

A telephone marking service offers independent verification of results (see the monthly MCQ papers in C+D for details). If you wish to register for Pharmacy Update, please contact Pauline Sanderson on 01732 377269.

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Review questions metformin heart ban

A BMJ review has questioned the evidence for contraindicating metformin in all patients with heart failure.

The authors questioned the link between metformin and lactic acidosis, saying that in the majority of case reports lactic acidosis could have been due to other causes, and that there is no evidence of lactic acidosis in patients with type 2 diabetes with no cardiac, renal or liver failure.

Further, the review found evidence that use of metformin in heart failure might be associated with lower mortality and morbidity

The authors observed that reports of lactic acidosis have not increased, even though increasing numbers of physicians are prescribing metformin for heart failure patients in contravention of the contraindication.

Further studies are needed to assess the traditional contraindications to metformin, the reviewers concluded.

BMJ 2007; 335: 508-12

Study suggests simvastatin dangers

Patients who switch from atorvastatin to the cheaper simvastatin may be at a 30 per cent increased risk of disease or death due to cardiovascular causes, an analysis of outcomes of switching has suggested.

Led by atorvastatin manufacturer Pfizer's cardiovascular medical manager, the analysis was presented at the European Society of Cardiology Congress, and is currently awaiting publication in The British Journal of Cardiology.

Some 9,009 patients who continued on atorvastatin were compared with 2,511 who switched from atorvastatin to simvastatin. The two groups were matched, based on risk factors, and the authors adjusted for residual imbalances between the groups.

A Pfizer press statement on the controversial observational study described it as 'hypothesis-generating'.

SMC accepts natalizumab and pioglitazone, but rejects levetiracetam

The Scottish Medicines Consortium has accepted natalizumab (Tysabri, Biogen Idec) for restricted use in patients with highly active relapsing-remitting multiple sclerosis and specific MRI results.

It has also accepted pioglitazone (Actos, Takeda UK) for use in combination with insulin in patients in whom metformin is contraindicated or not tolerated.

Also successful were capecitabine (Xeloda, Roche) for use in advanced gastric cancer and tacrolimus (Advagraf, Astellas Pharma) for preventing rejection of liver and kidney transplants.

The epilepsy treatment levetiracetam was refused for a range of indications (Keppra, UCB Pharma).

http://www.scottishmedicines.org.uk

In brief

Tangerine peel salvestrol kills cancer cells
Research presented at the British Pharmaceutical Conference suggests that a compound called salvestrol Q40 in tangerine peel can kill certain human cancer cells. The compound is found in the skins of fruit, and authors have suggested that the lack of fruit skins in modern diets may be one reason for the increasing numbers of some cancers.

Depression worse than chronic disease
Depression is more damaging to health than chronic diseases including angina, arthritis, asthma and diabetes, according to researchers working on data from the WHO World Health Survey.
Lancet 2007; 370: 851–8

GPs ignore BTS on bronchodilator syrups
Australian researchers have revealed evidence that British GPs are continuing to prescribe bronchodilator syrups for children in contravention of BTS guidance. Although prescriptions for syrups fell strongly during 2006, doctors still issued 121,000 prescriptions despite recommendations to the contrary.

HPA warns on mosquito virus in Italy
The Health Protection Agency has warned travellers about an outbreak of chikungunya virus in the Emilia Romagna region of Italy. Some 150 cases have been reported and one death. No vaccine is available to protect against the infection.
http://tinyurl.com/2gktkn

Nicopatch® and Nicopass® are nicotine replacement therapy products. Further information is available on request from Wockhardt UK Limited, Ash Road North, Wrexham Industrial Estate, Wrexham LL13 9UF, UK. Prescribers are recommended to consult the Summary of Product Characteristics before prescribing, particularly in relation to side-effects, precautions and contra-indications.
Legal category: GSL.

Nrt48/07/b August 2007

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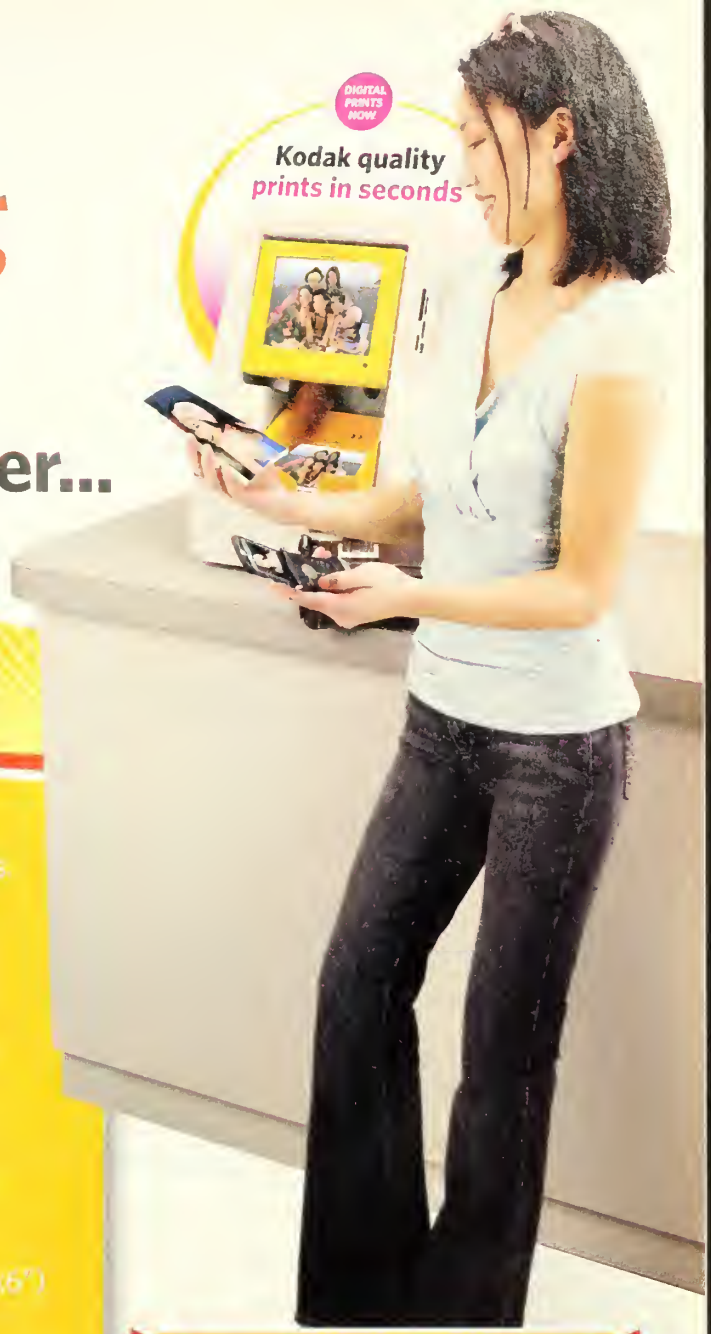

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11th October	**Manchester - Hilton Manchester Airport**
17th October	**Bristol - Hilton Bristol**
24th October	**Belfast - Hilton Belfast**

All events run 3 - 9pm. †Please phone for roadshow times for the Birmingham event.

To reserve your place or to find out more, contact Esta Charles on **0870 460 8199** or email **esta.charles@tetenal.com**

Kodak

Whiter shade of teeth

The Brilliant home tooth whitening range from Lornamead has been updated with an improved formula and new packaging.

Ideal for first time users, the Tooth Whitening Starter kit claims to whiten teeth by four shades (previously three) in a week. For seven shades lighter, up from five for the old formula, the Tooth Whitening kit offers a three-step process, while for whitening on the go, the Whitestick provides a quick top up, says the company. Completing the line-up, Whitening toothpaste can be used as part of an ongoing whitening regime.

The Brilliant range is free from hydrogen peroxide and is one of only two whitening kit brands complying with the Cosmetic Products (Safety) Regulations, says Lornamead.

For more info:
Lornamead
Tel: 01276 674000

Chart topping Brolene

The Brolene range now claims top spot in the infected eyecare pharmacy market with a 41 per cent share (source: IMS data, week 29), claims manufacturer Sanofi Aventis.

The five-strong range comprises Brolene Cool eyes, Eye ointment and Eye drops and Brochlor Eye drops and the recently launched Ointment.

Supporting the range, training resources including an electronic pharmacy guide and point of sale materials are available. Sanofi Aventis pledges to continue to focus its promotional activity on the complete range with further trade advertising and in-store support.

For more info:
Laser Healthcare
Tel: 01202 449700

Omron BP monitor tracks morning surge

Omron has launched a fully automatic upper arm blood pressure monitor that detects morning hypertension, a major risk factor for heart attacks and strokes.

The M10-IT's average mode tracks the early morning surge in blood pressure that makes heart attacks and strokes common at this time, says Omron, allowing informed decision-making about lifestyle changes to offset the risks.

As well as PC connectivity, irregular pulse detection and memory for 84 measurements for each of two users, it automatically sets the correct inflation pressure.

The M10-IT's launch comes in time for the Blood Pressure Association's awareness week, starting on Monday.

Price: £99.95
Pip code: 328-7679
For more info:
Tel: 0870 750 2771
www.omron-healthcare.com

Vicks opens one-stop shop

Vicks has launched a raft of products for the winter season, positioning itself as the only brand to offer the complete solution from cold defence through to treating coughs, colds and flu.

Merchandising support aims to simplify the fixture, helping the one in six customers who leave the fixture empty handed make a purchase. Dubbed the 'Solution centre', the shelf display puts products into four colour coded groups according to their activity. The centres will deliver an incremental £5 million sales to the category, claims manufacturer P&G.

Vicks Daymed is a new treatment for cold and flu symptoms. Containing paracetamol and phenylephrine, the product is available in blackcurrant and lemon flavoured hot drink sachets

formats. Available next month will be cough syrups in levomenthol and dextromethorphan variants and lozenges, all three with honey. For sore blocked noses, Sinex Soother with aloe vera is a new option.

Meanwhile, the pharmacy-only Medinite has been reformulated and renamed Medinite Complete. Backed up by clinical trials, says P&G, the product contains paracetamol, dextromethorphan, pseudoephedrine and doxylamine to relieve cold symptoms during the night.

Price: Daymed drinks £4.49/10, capsules £4.49/16;
Sinex Soother £3.99;
cough syrups £5.35/180ml, lozenges £5.35/12
Procter & Gamble
Tel: 01932 896000

Products in brief

Twinkle toes

Scholl's Party Feet range has added Starlight Invisible Gel Cushions (£4.99). Available over Christmas, it will help banish foot pain associated with shopping and partying, says SSL.
SSL International
Tel: 0870 122 2689

Brands move on

Pfizer Consumer Health has transferred to McNeil. Brands affected are Actifed, Anusol, Benadryl, Benylin, Calpol, Listerine, Migraleve, Regaine and Sudafed.
McNeil Products Ltd
Tel: 01628 822222

T&R sells 10 brands

Thornton & Ross has announced the sale of 10 OTC brands to Actavis. Affected products include Cymalon, Gastrocote, Orovite, Sominex and Yeastvite. T&R will handle sales this month.
Thornton & Ross
Tel: 01484 842217

Re-spray for Aloclair

Mouth ulcer treatment Aloclair is being relaunched with new packaging. The spray format has a new nozzle for improved hygiene and precise application. A new gel format will join the brand next month. PR activity supports.
Dexcel Pharma
Tel: 01327 312266

Products advertised on TV next week

Bassett's Soft & Chewy Omega 3: GMTV, Sat
Benefiber: All areas
Deep Freeze Patch: All areas, except GMTV, C4, five
Frontline: GMTV, Sat, five
Gaviscon Double Action: All areas
Haliborange Omega-3: C4, E4
Halos n Horns: Sat
Listerine Total Care: All areas
PharmaSite for next week: Zantac – windows, Zantac – in-store, Zantac - dispensary
Pharmacy channel: Solpadeine Plus, Imigran Recovery, Clearly Herbal Natural Baby Wipes

A-Anglia, B-Border, C-Central, C4-Channel 4, five-Channel 5, CAR-Carlton, CTV-Channel Islands, G-Granada, GMTV-Breakfast Television, GTV-Grampian, HTV-Wales & West, LWT-London Weekend, M-Meridian, Sat-Satellite, STV-Scotland (central), TT-Tyne Tees, U-Ulster, W-Westcountry, Y-Yorkshire

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Pain relief is an important category for your pharmacy and customers often prefer to seek advice from you or your fellow pharmacy team members instead of making an appointment to see their GP. **To offer customers the most up-to-date knowledge and developments, your continuous training is essential.** You have to be confident in your knowledge of such an important category, like pain relief, if your customers are to benefit from your help and advice. **That's why it is so important that you enrol in the Nurofen Academy.**

The Nurofen Academy is a comprehensive and interactive training programme especially written for pharmacy support staff. Each of the five modules carries the NPA Training Seal so that you can be sure that it is the best training you can get.

Over 10,000 pharmacy assistants have already enrolled and have received their first module. **If you register now, you can still receive the first module along with the second in October, and each subsequent module as they become available.**

Incentives for your success!

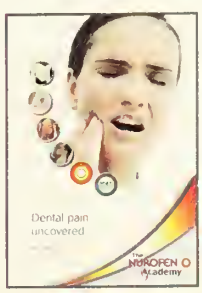
We are sure that you will enjoy participating in the Nurofen Academy and will become more confident about dealing with customers as a result. And to reward you for completing the modules you could receive:

Certificate: After you have successfully completed this year's modules and another after you have successfully completed the modules in 2008.

Pain Advisor badge: You will receive a lapel badge to show customers that they can trust your help and advice.

Wall chart: Your pharmacy will be sent a useful diagnostic wall chart showing painful conditions and their treatment.

Free entry into a prize draw to win a year's supply of tea and coffee break treats for your pharmacy.



The five modules are:

1 General Pain

Explains how pain occurs, how we define pain and the different active ingredients used to manage pain.

2 Painkillers Uncovered

Looks in more detail at painkillers. Considers the advantages and disadvantages of the different formats available and explores how customers reach their decision as to which product to purchase.

3 Headaches and Migraine Uncovered

Considers the different types of headache and their treatment, looking in-depth at migraine sufferers and their symptoms.

4 Back, Muscle and Joint Pain Uncovered

Explains the difference between back, muscle and joint pain. Looks at causes and treatments, including non-drug treatments.

5 Dental Pain Uncovered

With many customers no longer registered with a NHS dentist, the pharmacy is becoming a valuable source of advice regarding dental pain. This module describes the signs and symptoms of dental pain and investigates the treatments that can be recommended by pharmacy staff.

REGISTER NOW!

Either:

1. Call 01284 717 693

2. Fax back your list of names and pharmacy details to 01284 717 699

3. Send your list of names and pharmacy details to:

The Nurofen Academy
Communications International Group
207 Linen Hall
162-168 Regents Street
London W1B 5TB

The NUROFEN Academy

Developing practice in

Dry skin management can be a good starting point when developing services to support people with dermatological conditions. Both MURs and OTC advice are important ways to improve the effectiveness of treatment.

People with dermatological diseases can experience problems with their treatment for several reasons including insufficient information about the condition, the purpose of treatment, the method of treatment and the expected benefits.

Dry skin affects people with eczema (15-20% of children and up to 10% of adults) and is a feature of "sensitive skin" which affects about 50% of adults. It is by no means a trivial problem. For eczema sufferers it can be the forerunner of a flare up of their disease and for others it can lead to considerable discomfort and inconvenience. Furthermore, dry skin can be associated with troublesome itching and scratching, painful cracking of skin and distressing appearance.

There is a spectrum of dry skin conditions ranging from ichthyosis and severe eczema at one end to people who suffer from small patches of dry skin now and again. Dry skin appears to be the result of a combination of genetic predisposition, ageing and environmental factors.

Eucerin
DRY SKIN

Features of dry skin

Dry skin is likely to involve one or more of the following:

- A feeling of tightness, especially after showering, bathing or swimming
- A loss of plumpness - skin appears shrunken or dehydrated
- Skin that feels and looks rough rather than smooth
- Itching (pruritus) that sometimes can be intense
- Flaking or scaling
- Fine lines or cracks
- Redness
- Deep cracks that can bleed

Eczema on the foot of a 26-year-old woman. It can be caused by an allergy or irritation from substances such as detergents, but often occurs for no known reason.

Management of dry skin

Successful management of dry skin depends on selecting appropriate emollient products and using them correctly. Treatment failure and non-compliance is often due to misunderstandings about the most effective ways to use emollients (see below)

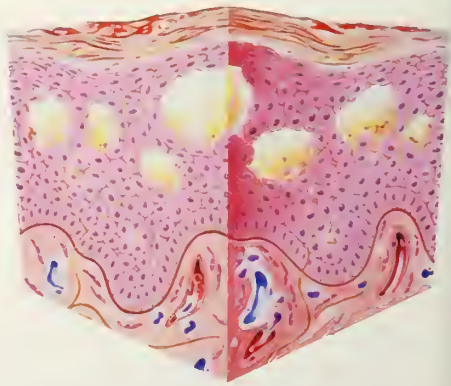
Treatment failure with emollients often occurs because people:

- Apply only small amounts of emollient
- Do not apply emollients frequently enough
- Do not use the most appropriate emollient
- Undo the benefits of emollients by using inappropriate wash products
- Do not get the expected improvement because of incorrect use so regular application lapses

In the normal situation water loss from the skin is kept to a minimum through the actions of the skin lipids in the stratum corneum and natural moisturising factor (NMF), a mixture of substances that hold water in the epidermis. Water loss from the skin surface is increased when the skin barrier is damaged, for example by disease or removal of lipids by soap or solvents.

Emollients or moisturisers are used to restore moisture to dry skin. Emollients work by forming a semi-permeable film over the skin that reduces water loss from the skin surface. Some emollients also contain humectants such as urea or glycerine. These agents attract water and in emollients they work by drawing water from the dermis into the epidermis. Emollient products that contain humectants are particularly useful for rehydrating dry, flaky skin. In practice, the moisturising effects often appear to be more sustained than with humectant-free products.

Greasy emollients are harder to spread and more occlusive. They can be useful for very dry skin but are often inconvenient to use in the daytime so compliance is poor. Light creams are easier to spread but are less occlusive and are generally less effective. Many modern emollients are both rich, that is, have a high lipid content, and are easily absorbed. (e.g. the Eucerin Dry Skin Relief range)



Eczema. A section through the epidermis of human skin affected by eczema. Eczema is a skin inflammation characterised by an itchy pink rash and crust on the skin. Fluid accumulation is seen between the cells of the epidermis (pink folded layer) causing spongiosis (separation of the cells). Clumps of epidermal cells have disintegrated to form large yellow vesicles containing inflammatory cells. These vesicles can rupture onto the surface of the skin forming crusts.

dermatology

Eucerin®

DRY SKIN

Support for self-care for people with dry skin

Self-care is the norm for most people with dry skin and it is important to be able to guide them towards effective treatment.
Two common situations are:

1. Extreme conditions dry out skin

After a beach holiday a young woman finds that the combined effects of sun, sea and swimming pools have resulted in her sensitive skin becoming extremely dry, rough to touch and uncomfortably itchy in places. She has used her usual moisturiser with little effect.

Action:

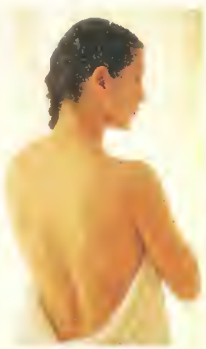
- Explain that the lotion she is using may not be rich enough to replenish and restore lost skin moisture to the damaged skin.
- Suggest a rich, humectant-containing emollient such as Eucerin® Dry Skin Creams with 5% or 10% Urea depending on the severity of the dryness or Neutrogena® Dermatological.

2. Frequent washing dries out skin

A nurse complains of dry itchy skin especially on her legs – she asks for something good for dry skin. She likes to have a long, hot soak in the bath after work, she takes a shower in the morning and on some days another shower after going to the gym.

Action:

- Explain that soaking in the bath removes skin lipids, especially if bubble bath is used; a warm shower would be better for her skin. Ordinary soaps and shower gels will also remove skin lipids.
- Suggest routine use of emollient after bathing. It should be applied within minutes of coming out of the bath or shower to restore the lost skin lipids, before the skin becomes visible dry and flaky. A richer (greasier) product could be used at night and a lighter product during the day.



Opportunistic MURs for patients with dry skin

MURs provide the opportunity for formal intervention when prescribed treatment has been misunderstood or used incorrectly.
Two common situations are:

1. Use of too little emollient

A patient who has been prescribed a topical corticosteroid and an emollient product for eczema. The Patient Medication Record (PMR) shows that the patient collects the steroid regularly but uses little of the emollient. He is disappointed with the results of treatment. During the MUR it turns out that he uses the steroids because he was told it was the "active" treatment and has not used the emollient because it is "just a moisturiser".

Action: Explain that:

- Emollients and steroids are more effective if used together – well-hydrated skin absorbs active treatment better. A product such as Eucerin Dry Skin Intensive 10% Urea Treatment lotion would be suitable.
- As a rule of thumb he should be using about 10 times as much emollient as corticosteroid.

2. Failure to use suitable wash products

A patient with eczema can control it for most of year with prescribed emollients alone but finds that in the winter "it gets out of control" and her usual emollient does not appear to work. Also, the dry skin is very itchy. During the MUR, it emerges that she uses ordinary soap and detergents to wash. It is likely that the drying effects of soap are made worse by the effects of central heating and cold weather in the winter and tip the balance.

Action:

- Explain the importance of using emollient wash products/soap substitutes to avoid undoing the benefits of emollient treatment. Eucerin Dry Skin Relief Shower and Bath Therapy would be one option. It also contains polidocanol which can help to reduce itching. Aqueous cream would be suitable for hand-washing
- Suggest switching to a richer emollient e.g. one containing a humectant such as Eucerin Dry Skin Intensive 10% w/w Urea Treatment Cream during the winter.

Information and signposting

Provision of patient information leaflets and signposting can reinforce your advice. Patients support groups such as the National Eczema Society and emollient manufacturers can both be useful sources.

Resource:
National Eczema Society: www.eczema.org
Eucerin website: www.eucerin.co.uk
Talkeczema: www.talkeczema.com
British Association of Dermatologists: www.bad.org.uk

August 2007

Information relating to the GSL Licensed Eucerin Intensive 10% w/w Urea Treatment Cream (PL 14160/0003, PA 1159/1/1) and Eucerin Intensive 10% w/w Urea Treatment Lotion (PL 14160/0004; PA 1159/1/2). Eucerin is a registered trademark. Marketing authorisation holder Beiersdorf UK Ltd, Birmingham B37 7YS, UK. Active ingredients Urea EP 10% w/w. Directions Apply twice daily to the affected areas of the skin. Indications For the treatment of Ichthyosis, Xeroderma, Hyperkeratosis and Atopic Eczema/Dermatitis and other dry skin conditions. Precautions Do not use if sensitive to any of the ingredients in cream or lotion. Do not use on broken, inflamed skin. Do not apply to large areas of skin on patients with renal insufficiency. This cream or lotion could increase the penetration of some substances, such as medicines known as corticosteroids, dithranol or fluorouracil. Avoid contact with the eyes or other sensitive areas. Keep out of reach of children. For external use only. Legal category GSL. PL 14160/0003; PA 1159/1/1 (Cream) GSL PL 14160/0004; PA 1159/1/2 (Lotion). Pack size and cost 250ml lotion (£7.69), 50ml cream (£5.85), 150 ml cream (£9.23) To report any adverse reaction or to comment, please contact BDF Consumer Relations on 0121 329 8800.
Revised May 2006.

For more on skin conditions see C+D's clinical archive at:
www.dotpharmacy.com/dermatology

Dermatology: adding your expertise

Learning more about skincare is good for business and good for your customers. **Dr Christine Clark FRPharmS** talks to pharmacists developing expertise in this area

Skin problems are estimated to affect eight million people in the UK and many of these will make the local pharmacy their first port of call. For these reasons, expertise in skincare and dermatological topics is a significant asset for any pharmacy.

One of the commonest skin problems is atopic eczema, which affects up to 20 per cent of children and 10 per cent of adults, although around 50 per cent of adults say they suffer from 'sensitive skin'. Add to this acne, psoriasis, warts, fungal skin infections, contact dermatitis and miscellaneous rashes and a considerable workload emerges. About 15 per cent of GP consultations are concerned with dermatological conditions but the corresponding figure for community pharmacies is not known.

People with skin problems need a source of good quality information and care. Although these conditions are often dismissed as trivial, they can affect people's ability to work and function normally (for example, hand eczema) and can have a serious impact on self-esteem and psychological wellbeing.

Patients with prescribed treatment for skin problems can benefit from appropriate pharmaceutical support. Treatment failures in this group of patients often arise from misunderstanding or a simple lack of information about the purpose of treatment, the correct method of application and the expected time frame for the course of treatment, which further compound the problem. Add to this the fact that many patients have more than one topical product, which may all be labelled "as directed".

Interventions around prescriptions

"Every prescription for a topical steroid – and almost any other dermatological product – is an opportunity to talk to the patient about emollients," says Allan Melzack, a C+D Pharmacy Champion and a pharmacist for Tesco in Handforth, Greater Manchester.

Many patients have no prescribed emollient or

"She'd tried loads of spot treatments Then I gave her **Free**derm."

www.freederm.co.uk

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*Source: IRI Infoscan All outlets June '07 MAT value market share. Freederm Trademark and Product Licence held by Diomed Developments Ltd, Hitchin, Herts, SG4 7QR, UK. Distributed by DDD Ltd, 94 Rickmansworth Road, Watford, Herts, WD18 7JJ, UK. **Indications:** For the topical treatment of mild to moderate inflammatory acne vulgaris. **Directions:** For adults, children and the elderly: Apply to the affected area twice daily after the skin has been thoroughly washed with warm water and soap. Enough gel should be used to cover the affected area. For cutaneous use. **Contraindications:** Not to be used in cases of sensitivity to any of the ingredients. **Precautions:** For external use only and to be kept away from the eyes and mucous membranes, including those of the nose and mouth. If excessive dryness, irritation or peeling occurs reduce the dosage to one application per day or every other day. Although there are no specific restrictions to using Freederm during pregnancy or breast feeding, the potential risks are unknown. As with all medicines, care should therefore be exercised, particularly during the first trimester of pregnancy. **Side-effects:** The most frequently encountered adverse effect reported is dryness of the skin. Other less frequent adverse effects include pruritus, erythema, burning sensation and irritation. **Legal category:** [P] **Packs:** 25g, RSP £8.95. (£7.62 exc. VAT) PL 0173/0187 Revision Date: January 2005

do not understand the importance of using them and this is the ideal time to put that right. When steroid/antibiotic combination products, such as Fucibet, are prescribed it is important to ensure the patient knows when to stop using them, he continues.

Another critical situation is prescriptions for Dovobet (calcipotriol and betametasone) where it is essential to ensure that the patient has understood when to discontinue treatment and when to restart it to manage psoriasis effectively and minimise the risk of side effects, he explains."I suspect that many opportunities are completely missed," he says.

Pharmacists should be involved in taking in and, more importantly, giving out prescriptions; Mr Melzack recommends delegating dispensing to technicians. You can identify a number of situations when receiving a prescription – some of these could lead on to MURs or interventions for which payments are made, he adds.

PGD scheme

A mechanism for ensuring that patients with prescriptions for topical steroids also had appropriate emollient therapy was set up by Uttlesford PCT. The scheme relied on a PGD, explains Trevor James, a pharmacist for Boots in Saffron Waldon.

Patients were contacted and offered a consultation with the pharmacist, which included a demonstration of how to apply the emollient and a 50g sample. The emollients were provided by the PCT and the pharmacist was paid £5 for each consultation. A second consultation was also permitted. When a suitable emollient had been found for the patient, a request was sent to the GP for continuing prescriptions. A 500g quantity was suggested.

The scheme ran for several months and was very successful, says Mr James. It was very well received by patients, and Boots found a surprising number of people who had been prescribed topical steroids but no emollients, he says.

In one case, a teenage girl with persistent eczema presented with a prescription for a topical steroid. During a consultation Cathy James – Trevor's wife who is also a pharmacist in the same pharmacy – explained the importance of emollient use and avoidance of soap and detergents. The patient's major problem was with eczema affecting her hands and Mrs James recommended that she wear suitable gloves while washing her hair.

A month later the girl returned to the pharmacy and her skin was clear. "She was ecstatic," recalls Mr James. Neither the girl nor her mother had previously realised the importance of these small steps, he adds.

Allan Melzack, C+D Pharmacy Champion and pharmacist for Boots in Handforth, Greater Manchester, promotes the pharmacy profession in the world of dermatology

Using audits

Conducting an audit of the use of emollients proved a good way to improve patient care for Linda Hirst of Cullingworth Pharmacy, Cullingworth, Bradford, also targeting children using topical steroids. The audit was undertaken by a pre-registration student working in the pharmacy. Ms Hirst says they found lots of people who were not using enough emollients and people who did not know when to apply them – there were numerous opportunities for counselling. "We have to do two audits each year, one of which is practice-based, so this is a great opportunity to kill two birds with one stone," she says.

Health promotion

A skin cancer awareness health promotion project was another initiative from Cullingworth Pharmacy. Ms Hirst explains: "We got pictures of melanomas for a window display, gave out leaflets and displayed high SPF sun creams. We got a basic pack of leaflets from the PCT but we were able to obtain additional material (at no cost) from a local health promotion library. We found we could also rent high quality display material from them for short periods."

Both of the projects at Cullingworth Pharmacy were undertaken by pre-registration students. "You don't have to do it all yourself – you can plan the project and get students and medicines counter assistants involved," recommends Ms Hirst.

She adds that if you can make the time, there is so much more you could do in this field. For example, you could make contact with local schools and help with educating people about treatments for head lice and contribute to sun protection campaigns.

Helping patients to use dermatological treatments effectively can be professionally rewarding and, as these examples show, there are many ways to introduce good skincare into day-to-day practice.

> "Every prescription for a topical steroid – and almost any other dermatological product – is an opportunity to talk to the patient about emollients"

Voted Patients' Favourite Emollient[1]

Aveeno Cream has been voted patients' favourite emollient every year for the past 10 years in the North Tees & Hartlepool NHS Trust emollient assessments.[1]

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Discover nature's secret for beautiful, healthy looking skin

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[1]Dean B, Carmichael A. Emollient Packs – Choice in Dermatology Clinical Pharmacy Europe Summer 2006. [2]User tests – Aveeno. Data on File, Johnson & Johnson. [3]Patient Diaries. Data on File, Johnson & Johnson.

For more on skin conditions see C+D's clinical archive at:
www.dotpharmacy.com/dermatology

> "It is essential to ensure that the patient has understood when to discontinue treatment"

OTC interventions

OTC sales also provide opportunities to give additional advice. For example, a sale of hydrocortisone for insect bites is a good time to warn against the use of topical antihistamine or local anaesthetic for this indication because of the risks of sensitisation.

Another situation is requests for treatment for fungal toenail infections – with careful questioning you sometimes find there is longstanding fungal infection of the whole foot and more extensive treatment is needed.

There is still a major problem with 1 per cent hydrocortisone for use on the face for eczema, says Mr Melzack (pictured above left). He says that although it is known to be safe to use, if the pharmacy puts the patient first and sells it, it faces possible legal consequences. If the pharmacy refers to the doctor, it will be prescribed but treatment is delayed and discomfort prolonged.

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E45

E45 Itch Relief Cream. E45 Itch Relief [illegible] 3.0% w/w and urea 5.0% w/w. [illegible] eczema, [illegible] and [illegible] pruritic and/or [illegible] treatment and follow-up treatment of these skin diseases. **Dosage and administration:** *Adults, the elderly and children:* Apply to each affected area twice a day. The duration of treatment depends on the clinical response. **Contraindications:** Patients with known hypersensitivity to any of the ingredients. It should not be used to treat acute erythroderma, acute inflammatory, oozing or infected skin lesions. **Special warnings and precautions for use:** May cause irritation if applied to broken or inflamed skin. **Pregnancy and lactation:** There are no specific restrictions concerning its use during pregnancy, but it is not to be used on the breasts immediately prior to breastfeeding during lactation. **Undesirable effects:** E45 Itch Relief Cream has been reported to cause a burning sensation, erythema, pruritus or the formation of pustules. Contact allergy has also been reported. **Package quantities:** 50 g and 100 g tubes. **MIPP:** 50 g £3.99, 100 g £5.44. **Legal category:** GSL. **Product licence number:** PL 00327/0122. **Product licence holder:** Crookes Healthcare Ltd, Nottingham, NG2 3AA. **References:** 1. NES Survey, March 1999. 2. Puschmann M *et al* The German Dermatologist 1992;8;1138–1143. 3. Vieillu D *et al* Z Hautkr 67;9;816–821.

Natural remedy for Acering

Acering has extended its brand portfolio, gaining Morningside's former OTC brand, Refer Cracked Heel Cream. Formulated with herbal and fruit ingredients, Refer is the only cracked heel cream on the market to offer a natural remedy, says Acering. Refer's active ingredients combine seven natural extracts, including tamarind to remove dead skin cells and sesame seed oil to rehydrate the skin. Cracked heels are generally painful for sufferers and can lead to medical problems. Acering has introduced a launch offer price of £3.99/50g to help attract consumer awareness (standard rrp £4.99/50g). Retailers interested in the product should contact Acering on 01159 183309.

"You don't have to do it all yourself – you can plan the project and get students and medicines counter assistants involved"

Scratch resistance

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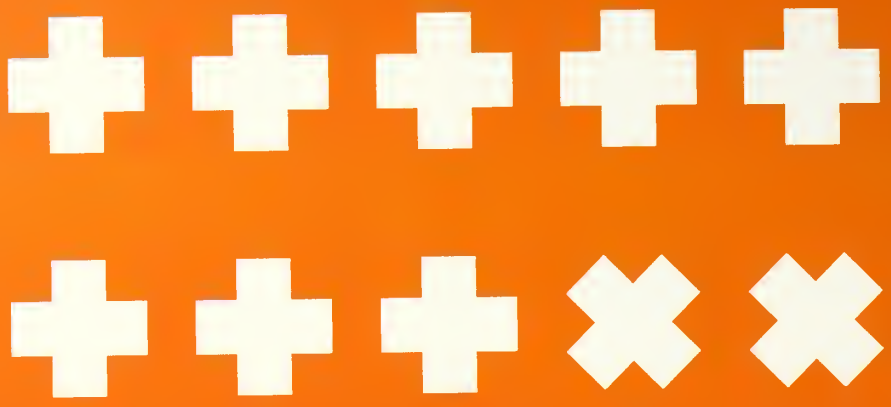
Date of preparation: March 2007 CHCSK04-84E



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*The Thinking Shop, 2006
†Photobiology Laboratory MEDUNSA, 2006

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Closing Date 31st September 2007

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From: **Hawkeye on the web**

Date: **Sat 15.09.07**

Subject: **Supermarket sweep**

Pharmacy leaders say growth in online pharmacy is a **good thing**

The growing clout of supermarkets within the pharmacy sector was underlined last week with the news that Asda is to offer over 1,000 OTC products on its website through an agreement with Pharmacy2U (asda-pharmacy.co.uk).

The offering is a powerful combination of Asda's strong brand with Pharmacy2U's knowledge of both pharmacy and the online business model. For consumers, this opens up a convenient route to purchase medicines at a price that will make them pat their change-filled back pockets with joy (tinyurl.com/3578e9).

Asda's move – undertaken with support from its owner, the US retail behemoth Wal-Mart – will inevitably generate competition concerns. There are also likely to be fears that Asda's competitors will follow suit, even though Sainsbury's and Morrisons, for example, have said they do not currently have e-pharmacy plans.

But pharmacy leaders say growth in online pharmacy is a good thing. Instead of providing damaging competition, they argue that the rise of e-pharmacy among the bigger retailers could create a 'halo' effect for the rest of the community pharmacy sector. The Independent Pharmacy Federation, for example, says e-pharmacy represents supplementary trade rather than cannibalisation of existing sales.

In theory, the business case for independents developing a 'clicks and mortar' business is strong. An online channel provides patients with convenient access to a retailer they know and trust. What's more, pharmacists are equipped with

the knowledge and expertise to combat the commoditisation that drives down price.

The challenge is in translating these unique skills into a successful e-business model. The healthcare focus might already be there but the marketing or 'Asda' element of the equation is not as strong.

Pharmacies that have bucked the trend have done so by pushing their marketing credentials. An example is e-pharmacy pioneer Garden Pharmacy in Covent Garden, London (www.garden.co.uk), which pushes its online store under the strapline 'Total health and beauty'. In tune with its target audience, the site promotes make-up, skincare and health and beauty products with a strong emphasis on the brands that consumers know well. The emphasis is on customers rather than patients.

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Transplant patient says 'Have a heart'

Jennifer Sutton, 23, recently had the unique experience of seeing her heart in a jar.

After a transplant in June she donated her diseased heart to the Wellcome Collection where it was displayed as part of a temporary exhibition.

Jennifer suffered from restrictive cardiomyopathy, a fatal disease that causes the organ to stiffen. She let her heart be exhibited to raise awareness of the condition. www.wellcomecollection.org

Adrian Brooks, 2007, © Wellcome Library London

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